WOODROW WILSON SCHOOL
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PAYMENT REFORM IN DIVERSE PRACTICE SETTINGS

Making Patient-Centered Medical Homes and Episodes of Care Work for Low-Volume Medicaid Providers in Tennessee

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List of Acronyms

ACA	Patient Protection & Affordable Care Act
ACE	Acute Care Episode
ACGME	Accreditation Council for Graduate Medical Education
ACO	Accountable Care Organization
AHEC	Area Health Education Centers
AHRQ	Agency for Healthcare Research and Quality
BCBST	BlueCross BlueShield of Tennessee
BH	Behavioral Health
CCHI	Cumberland Center for Healthcare Innovation
CCNC	Community Care of North Carolina
CDC	Centers for Disease Control and Prevention
CJR	Comprehensive Care for Joint Replacement
CME	Continuing Medical Education
CMS	Centers for Medicare & Medicaid Services
ED	Emergency Department
EHR	Electronic Health Record
FPL	Federal Poverty Level
GDP	Gross Domestic Product
HIT	Health Information Technology
HRSA	U.S. Health Resources and Services Administration
IT	Information Technology
MCO	Managed Care Organization
MLN	Medicare Learning Network
MSA	Metropolitan Statistical Area
NCQA	National Committee for Quality Assurance
NQF	National Quality Forum
PAP	Principal Accountable Provider
PCMH	Patient-Centered Medical Home
PCP	Primary Care Provider
PMPM	Per-Member-Per-Month
QIN-QIO	Quality Innovation Network – Quality Improvement Organization
QuILTSS	Quality Improvement in Long Term Services and Supports
RHC	Rural Health Clinic
SIM	State Innovation Models
SPMI	Severe and Persistent Mental Illness
TAG	Technical Advisory Group
TCOC	Total Cost of Care
TMA	Tennessee Medical Association
tnREC	Tennessee Regional Extension Center

Executive Summary

This report assesses the Patient-Centered Medical Home (PCMH) and episodes of care strategies that are being implemented as part of the Tennessee Healthcare Innovation Initiative. It specifically focuses on the challenges the two strategies face in engaging low-volume health care providers to encourage their effective participation.

The report is based on a series of stakeholder interviews conducted in the fall of 2015 and claims data provided by TennCare. The interviews and data were used to guide a literature review that focused on the challenges faced by low-volume providers in successfully participating in such strategies, as well as best practices for implementing the strategies for these providers.

A set of challenges for the PCMH strategy were identified around payment structure, eligibility and reporting requirements, health IT, practice resource pooling, and behavioral health integration. A separate set of challenges for the episodes of care strategy were identified regarding lack of risk-adjustment alignment, provider downside risk, and the data reports given to physicians and other providers. The challenge and importance of appropriate physician education and outreach for both strategies are also discussed.

The report ultimately provides a series of recommendations for TennCare to consider to address each of these challenges with the goal of improving the implementation of the PCMH and episodes of care initiatives in order to increase the successful participation of low-volume providers and help Tennessee achieve the full promise of the Innovation Initiative.

Summary of Recommendations

TennCare has implemented Patient-Centered Medical Homes and episodes of care as part of the Tennessee Healthcare Innovation Initiative. This report identifies a number of challenges in engaging low-volume providers in these efforts. We recommend that TennCare consider the following approaches to improve the feasibility of these strategies for low-volume providers.

Part I: Patient-Centered Medical Homes

Payment Structure

1. TennCare should consider setting a specific range for the new clinical activities per-member-per-month (PMPM) payments that managed care organizations (MCOs) will pay to PCMH-certified practices. By setting a PMPM payment range, with specific dollar figures that appropriately incorporate the health IT and economy of scale-needs of low-volume practices, the state can reduce uncertainty for practices by guaranteeing a minimum payment amount upon which providers can rely.

2. TennCare should consider delaying cost-based outcomes payments until the second year of the PCMH strategy to allow time for practice changes to be fully adopted.

Eligibility and Reporting Requirements

1. TennCare should consider standardizing eligibility and reporting requirements as well as risk adjustment methodologies across MCOs, and MCOs should be limited in their ability to place additional certification and reporting requirements on PCMH practices above those required by the state.

2. TennCare should consider setting a minimum panel size by taking into account the extent to which the PMPM payment for new clinical activities will enable practices to afford acquiring the necessary care coordination staff and practice supports.

Practice Resource Pooling

1. TennCare should consider allowing low-volume providers below a determined threshold to pool across practices in order to achieve shared savings. This pooling of low-volume practices into a larger network should be an opt-in initiative in an effort to foster physician-led networks.

2. TennCare should seek to provide practice-level short-run support and network-level long-run support. At the practice level, TennCare should consider providing IT-related infrastructure improvements, data-related training and coaching, and sample legal agreements. At the network level, TennCare should consider ways to build on the Care Coordination Tool currently under development by providing additional clinical data analytic technology to enable the sharing of cost and quality information between practices utilizing separate EHR systems, as well as centralized, shared data analysis and care coordination staff.

Behavioral Health Integration

1. TennCare should consider building dedicated financial support into the New Clinical Activities payment for increased behavioral health capacity at PCMH-certified practices.

2. TennCare should consider including a behavioral health integration measure, such as substance use screening reporting, as an additional criterion in the outcomes-based payments alongside the current total cost of care (TCOC) measures.

3. TennCare should encourage the formation of formal arrangements between PCMH-certified practices and local behavioral health professionals to enable easier patient referrals and better integration of services.

Part II: Episodes of Care

Non-Alignment of MCO Risk Adjustment Formulas

1. TennCare should consider requiring all MCOs to use the same risk-adjustment methodology.

Downside Risk

1. TennCare should consider allowing providers who exceed the average risk-adjusted episode cost but meet the defined quality measures to pay lower penalties (e.g., less than 50 percent).

2. TennCare could exclude providers who do not treat a minimum number of valid episodes in a given year from two-sided risk, which would eliminate the potential losses from downside risk faced by the lowest-volume providers.

3. TennCare could give low-volume providers solely limited upside risk rather than larger upside and downside risk.

Provider Data Reports

1. TennCare should consider opportunities for improvement to existing episode of care reports, including encouraging payers to provide more detailed, transparent, and actionable information where feasible.

2. TennCare should explore ways to more succinctly deliver key information to Principal Accountable Providers (PAPs), also known as quarterbacks, such as an executive summary of each quarterly report.

3. TennCare should assess barriers inhibiting quarterbacks from reviewing episode of care reports and use this data to inform the design and delivery of episode reports in order to be optimally utilized by providers to promote high-quality and efficient care.

Part III: Physician Education and Outreach

1. TennCare should consider incentivizing physicians to attend PCMH and episodes trainings by offering Continuing Medical Education (CME) credits to participants and by making trainings free.

2. TennCare should consider ways to create a provider support and outreach coalition through existing networks.

3. TennCare should consider developing an enhanced online toolkit for providers and publicize it throughout the state.

4. TennCare should explore ways to offer multiple forms of education and training to assist practices implementing PCMH and episodes of care.

5. TennCare should consider cultivating outreach models, such as learning collaboratives, that rely on partnerships with providers in order to facilitate physician leadership and engagement.

6. TennCare should seek to foster continuous two-way communications with physicians and facilitate effective implementation through the use of a feedback system.

7. TennCare should pursue efforts to facilitate the alignment of values between TennCare and its providers with strategies that are framed in terms of the empirical literature with careful use of physician-friendly language.

Introduction

Tennessee has a long history of pioneering innovations in health care. In 1994, Tennessee replaced its state-run fee-for-service Medicaid program with TennCare, covering patients through per-member-per-month (PMPM) payments to Managed Care Organizations (MCOs) in order to reward quality of care rather than quantity of care.[1] Tennessee was only the second state in the country to transition its Medicaid program to managed care.[2] Amidst escalating health care costs nationwide, Tennessee has also led the country in slowing the growth of Medicaid costs.[3] A U.S. Government Accountability Office report last year predicted average Medicaid spending growth of 6.7 percent, while TennCare costs are only expected to rise 3.3 percent.[4]

Now Tennessee is charting an ambitious path on Medicaid payment and delivery reform. In 2014, the state was awarded a $65 million State Innovation Models (SIM) grant from the Centers for Medicare & Medicaid Services (CMS) that will fund the Tennessee Healthcare Innovation Initative which includes three far-reaching payment and delivery system reform strategies targeted at improving quality of health care while controlling costs. These strategies are (1) Primary Care Transformation, which includes scaling up multi-payer Patient-Centered Medical Homes (PCMH), (2) implementing episodes of care reimbursement, and (3) instituting outcomes-based improvements in Long Term Services and Supports.[5]

TennCare officials requested an examination of the first two strategies—PCMH and episodes of care—and recommendations detailing how TennCare can more successfully engage low-volume providers in these reform efforts to maximize the impact of the strategy.

In November 2015, stakeholder meetings were conducted with representatives of 13 organizations in Tennessee, including government agencies, health care providers, payers, research institutions, and advocates. Stakeholders were broadly supportive of TennCare reforms, and appreciative of the extensive consultation that was undertaken by program staff. There were, however, some concerns raised about provider capacity with regard to support staff, IT infrastructure, risk management, practice culture, and the necessity of provider education.

In addition to synthesizing feedback from stakeholder meetings, this report analyzes data and reviews best practices in academic literature and among other states implementing similar reforms. Based on these findings, 23 recommendations have been developed to address the challenges of engaging low-volume providers in TennCare's reforms.

In the following chapters, the report first discusses relevant historical context and background regarding health care in Tennessee. Next, the report analyzes TennCare data to better understand the demographics of low-volume providers and the challenges they face. This analysis revealed that low-volume providers are equally represented in rural and urban areas, a finding that informs our subsequent recommendations. The report also identifies the major hurdles providers encounter in implementing PCMH and episodes of care models, reviews best practices, and makes recommendations for addressing the identified challenges. Finally, the report proposes a robust physician education and outreach strategy in order to advance effective adoption of these reforms.

Background

Introduction to Tennessee: Economic and Regional Context for Health Reforms

Tennessee has experienced recent economic growth, though at a slower rate than the nation overall. In 2014, Tennessee's GDP grew 1.5 percent, compared to a national growth rate of 2.2 percent.[6] The state's unemployment rate was 5.6 percent in October 2015, above the national rate of 5.0 percent.[7] While Tennessee's overall economic indicators lag slightly behind those of the nation, health care is an economic bright spot, making up a significant and growing portion of economic activity in the state. A 2013 Brookings Institution report found that, while about 10.3 percent of jobs nationally are in the health care sector, health care jobs account for an average of 11 percent of jobs in the four major urban areas in Tennessee.[8] A recent study found that the size of the health care industry in the Nashville region alone has grown by more than $8 billion over the past five years, contributing just under $39 billion to the state's economy in 2014.[9]

TennCare, the state's Medicaid Agency, is implementing widespread health care reforms across a diverse state, with three regions that each have distinct economies, demographic characteristics, cultural identities, urban and rural landscapes, and health outcomes. The state's three regions, East, Middle, and West Tennessee, are depicted as the three stars on the state flag, and are enshrined in state law.[10] East Tennessee includes two of the state's largest cities—Chattanooga and Knoxville—and is also known for the Smoky Mountains.[11] The region's largest employer is the Tennessee Valley Authority, and both manufacturing and health and education services play a significant role in the region's economy. The region is characterized by foothills and the state's Central Basin. Within Middle Tennessee, rural areas surround Nashville, the state's capital and second-largest city. Middle Tennessee is currently experiencing faster population growth than the state's other regions.[12] This is partially driven by immigration growth in increasingly multicultural Nashville, where the number of foreign-born residents has more than doubled over the past decade, rising to 12 percent of the population in 2012.[13] In fact, as of that year, Nashville's immigrant population grew faster than that of any other American city. West Tennessee's low hills and plains are separated from the rest of the state by the Tennessee River. Memphis, the state's largest city, is located within West Tennessee and has historically been home to a large concentration of the state's African American population. With African Americans making up 64 percent of the city's population, Memphis ranks sixth among U.S. cities with regard to both the number and the proportion of African American residents.[14]

Tennessee's regional diversity serves as an asset but also poses a significant challenge in implementing statewide health care reform because health outcomes vary widely by region. Research has found higher rates of smoking and cancer, for example, in the Appalachian regions of East Tennessee.[15] In West Tennessee, obesity and related diseases play a dominant role in health care needs. Memphis's obesity rate of nearly 32 percent is the highest of any large city in the nation.[16] Other studies have similarly found regional disparities in health outcomes across the state.[17]

TennCare History

TennCare has undergone several major changes since transitioning to a managed care system in 1994. In subsequent years, in addition to standard Medicaid coverage, TennCare added pharmacy and nursing home benefits. It also expanded eligibility categories to include those who

lacked insurance access or had applications denied on the private market, among others.[18] However, by 2003, forecasts of rising future TennCare expenses generated attention and debate about reform options.[19] In 2005, under Governor Phil Bredesen, the state tightened eligibility for TennCare, disenrolling 190,000 members and restricted benefits, such as pharmacy benefits, for remaining members.[20] Stakeholder interviews suggested that this event remains on the minds of policymakers, providers, and the public.[21]

Since 2006, TennCare has required all MCOs to receive accreditation from the National Committee for Quality Assurance (NCQA), and was the first state Medicaid program to do so. Currently, TennCare is administered by three MCOs: Amerigroup, BlueCross BlueShield of Tennessee, and UnitedHealthcare.[22]

Although the Patient Protection and Affordable Care Act (ACA) called for states to expand Medicaid, the Supreme Court ruled in 2012 that the expansion was optional. Rather than pursuing the standard Medicaid expansion, in December 2014, Tennessee Governor Bill Haslam unveiled his proposal to expand Medicaid to additional Tennesseans through a Section 1115 waiver, which offers states greater flexibility in implementing demonstration projects that still achieve Medicaid objectives.

Governor Haslam's Insure Tennessee proposal offered residents from the ages of 19 and 64 with income levels between 101 percent and 138 percent of the federal poverty level (FPL) the option of choosing a defined benefit for the purchase of health care coverage or enrollment in a TennCare MCO.[23] The MCO option was accompanied by a Health Savings Account (HSA) that could reward healthy behavior.[24] With an estimated 280,000 to 300,000 Tennesseans in this coverage gap, the two-year pilot would have extended coverage to an additional 4.2 percent of the state's population.[25]

Coverage for this population would have been financed entirely by the federal government during the first year, with the federal contribution subsequently decreasing from 100 percent to 90 percent between 2017 and 2020.[26] Rather than allocating state funding for the remainder, Tennessee's hospitals pledged to fill the gap by paying the state share of additional costs, an estimated $74 million over two years.[27] However, the Insure Tennessee proposal was not able to be passed out of committee during a special legislative session called by Governor Haslam to review the bill in February 2015.[28]

While the Insure Tennessee proposal was not passed by the legislature in 2015, Medicaid enrollment has risen over the past several years, resulting in Tennessee displaying the highest enrollment growth in the country for a non-expansion state.[29] The increase in enrollment among those who were previously eligible may be due to the impact of publicity and advocacy surrounding passage of the ACA and taxpayers seeking to be in compliance with coverage requirements.[30] In Tennessee, enrollment in September 2015 was 23 percent higher relative to the same period in 2013, with 287,434 additional enrollees.[31] The rise in enrollment is not unique to Tennessee. While Medicaid enrollment increased by 23.3 percent between September 2013 and 2015 nationally (including both states that did and did not expand), it has increased by 10.6 percent over the same period among states that did not expand Medicaid eligibility.[32]

As of November 2015, TennCare covers 1.48 million Tennesseans, representing over 22 percent of the state's population.[33] Parents with incomes up to 101 percent of the FPL; pregnant women with incomes up to 200 percent of the FPL; older, blind, or disabled individuals who receive Supplemental Security Income; children whose parents earn up to 133 percent of the FPL; and certain other categories of individuals are eligible for coverage.[34]

State Innovation Models Grant

Tennessee was awarded a $65 million State Innovation Models (SIM) grant in 2014 to implement the Tennessee Health Care Innovation Initiative, three strategies designed to improve quality of care while reducing costs: (1) Primary Care Transformation, which includes scaling up multi-payer Patient-Centered Medical Homes (PCMH), (2) implementing episodes of care reimbursement, and (3) instituting outcomes-based improvements in Long Term Services and Supports.[35]

Patient-Centered Medical Homes (PCMHs) are a cost-saving measure to prevent the overuse of expensive emergency care by incentivizing preventive care and early interventions. PCMHs coordinate care for a single patient across all providers, including behavioral health specialists, with one primary point of contact. They also coordinate additional support services, such as transportation to appointments.

Under the SIM grant-supported transformation, all three MCOs will participate in a statewide PCMH program that will begin with 20-30 pilot practices in August 2016. The program will be scaled up by 2020 to include 65 percent of TennCare members in the state, approximately 850,000 Tennesseans.[36] As of 2014 about 200,000 TennCare patients were already receiving care thrrough PCMHs.[37] In addition, TennCare will create Health Homes with tailored and intensive behavioral health support specifically for patients with Severe and Persistent Mental Illnesses (SPMI). When Health Homes launch in October 2016, they are slated to serve all individuals with SPMI who qualify for the program.[38]

These reform strategies are promising because they can help reduce costs for the neediest patients, who currently account for a disproportionate amount of health care spending. In Tennessee, the 22 percent of TennCare patients with common chronic conditions (such as asthma, heart disease, and diabetes) account for 55 percent of spending. The 9 percent of patients with two or more chronic conditions account for 35 percent of spending alone.[39] Moreover, the 5 percent most costly patients account for almost half of total adjusted spending and 75 percent of hospital inpatient care.[40] In addition, the 20 percent of TennCare patients with behavioral health needs account for 39 percent of total spending.[41] If these strategies can better manage the care for these patients, the state could achieve dramatic cost savings overall.

The second strategy, episodes of care, is a payment reform that reimburses a group of medical professionals for the overall treatment of a condition rather than paying each physician for a specific service. Its purpose is to incentivize providers to reduce costs and improve outcomes in order to realize a portion of the cost savings. This reform began in early 2014 with three "episodes," acute asthma exacerbation, perinatal, and total joint replacement, and is scheduled to reach 75 episodes by 2020.[42] Tennessee has plans to roll out these episodes in the State

Employee Health Plan and potentially to the MCOs' commercial and Medicare Advantage members as well.[43]

The third strategy is a payment reform focused on the TennCare population receiving long-term services and supports. One aspect of the strategy, Quality Improvement in Long Term Services and Supports (QuILTSS), intends to link reimbursement with patient needs, patient satisfaction, provider training, and provider performance on quality indicators.[44]

This report focuses exclusively on the first two reforms, PCMH and episodes of care, and makes recommendations detailing how TennCare can more successfully engage low-volume providers in these transformation efforts.

Data: Cost and Geography

This report utilized TennCare claims data to assess cost trends and practice distribution geographically across the state. First, descriptive statistics of TennCare providers show the geographic distribution of low-volume providers and the average cost of patients in low-volume practices. Second, analysis of the highest cost TennCare patients reveals that urban and rural counties do not face systematically different populations among the highest spending 15 percent of TennCare members.

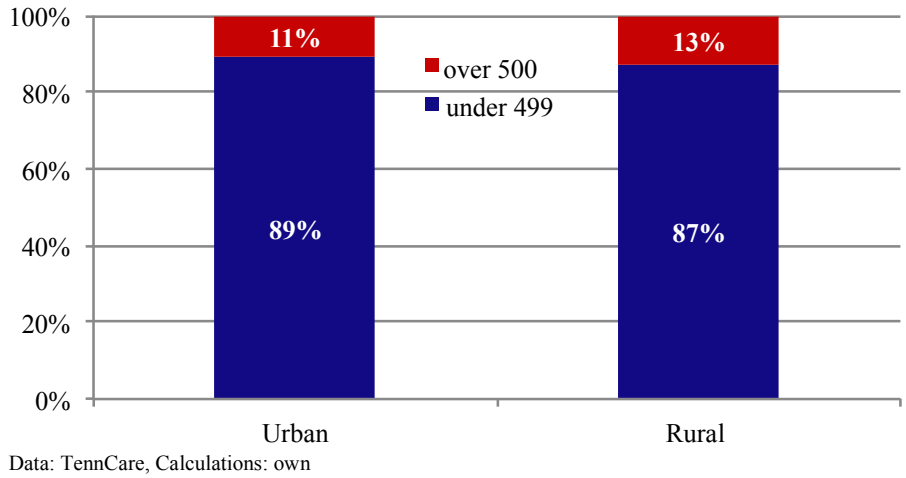
There are two important caveats to highlight about the data and subsequent analysis provided in this report. First, the classification of "low-volume" refers only to a practice's volume of TennCare patients, not to their overall patient panel size. Some number of these practices may be much larger practices with low volumes of Medicaid patients as a proportion of their overall patient panels. Second, the definition of urban and rural counties does not limit the definition of urban counties to those with major metropolitan hubs such as Nashville, Memphis, Knoxville, and Chattanooga. This analysis used the definition of metropolitan and nonmetropolitan counties from the Centers for Disease Control and Prevention (CDC) National Center for Health Statistics to define urban and rural counties.[45] Noncore and micropolitan counties were designated as rural, while large metro, medium metro, or small metro counties were designated as urban. Therefore, counties considered urban in this report include those with smaller metropolitan areas, despite the fact that much of the county might still be largely rural in nature.

It is also important to recognize that the vast majority of TennCare patients receive care at larger practices. The 11 percent of practices with TennCare patient panels above 500 account for 82 percent of annualized members.[46] Despite the concentration of patients in large practices, however, it is a small group of patients—5 percent—that account for almost half of the program's cost. As the data analysis that follows indicates, high-cost patients are not confined to either large-panel practices or urban areas.[47]

Low-Volume Providers

The distribution of practices by patient panel size is essentially the same in both urban and rural counties.

Figure 1: Practices by County Type and TennCare Patient Panel Size

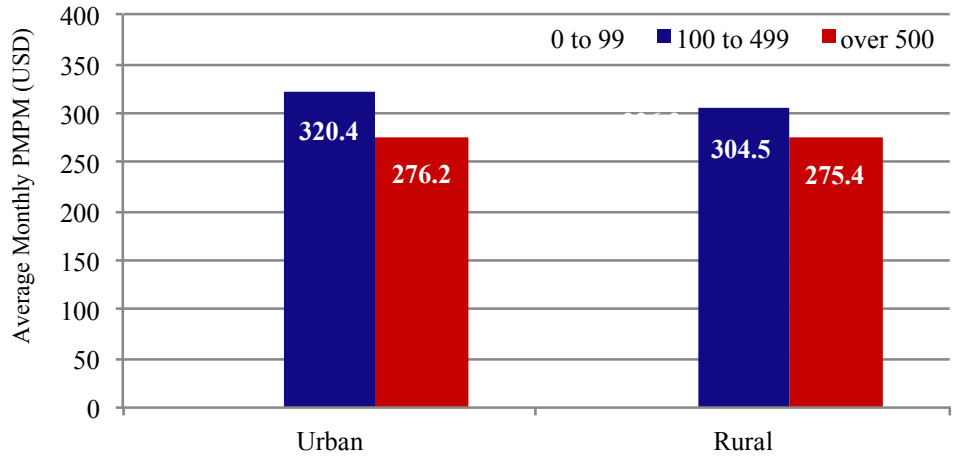


Data: TennCare, Calculations: own

As seen in Figure 1, over 87 percent of practices in both urban and rural counties have TennCare patient panels with fewer 500 average attributed monthly members. Therefore, the challenges of reforms for low-volume TennCare providers will be faced in both urban and rural contexts. Yet, as indicated above, the nature of these low-volume providers remains unclear. Some of these practices may be large practices with only a small number of Medicaid patients, or they may be practices with small patient panels altogether. The reform challenges faced by these two different types of practices would likely be different in some cases but similar in others. It may be helpful to pursue additional data to determine which practices have low volumes across their entire patient panels.

Also of note, practices with smaller TennCare patient panel sizes have higher levels of PMPM spending.

Figure 2: Average PMPM Spending by TennCare Patient Panel Size and County Type



Data: TennCare (note, PMPM is not risk adjusted), Calculations: own

Providers with TennCare patient panels of over 500 average attributed monthly members have similar PMPM spending levels in both urban and rural counties (see Figure 2). However, practices with patient panels under 500 average attributed monthly members have larger PMPM spending levels than practices with larger patient panels. This increase in PMPM spending is especially large for very low-volume providers, those with fewer than 100 average attributed monthly TennCare members. The increase in PMPM spending among small-panel providers is also larger in urban than in rural counties. These findings suggest that addressing the higher per-member costs for low-volume practices in both urban and rural contexts as part of the PCMH and episodes of care initiative will be critical to realizing overall cost reductions.

High-Cost Patients

Spending on the most costly 15 percent of TennCare patients does not systematically differ between rural and urban counties. Across distributions of spending, age, chronic diseases, and health categories, the population of TennCare patients treated in urban and rural counties looks very similar.

Table 1: Distribution of Highest Cost Patients and and Per-Member Per-Month TennCare Spending in Urban vs. Rural Counties*

	Urban Counties		Rural Counties	
	Proportion	Avg. Spending	Proportion	Avg. Spending
1-5%	74.3%	$32,850	25.7%	$31,299
6-10%	73.2%	$9,195	26.8%	$9,186
11-15%	72.2%	$6,081	27.8%	$6,076

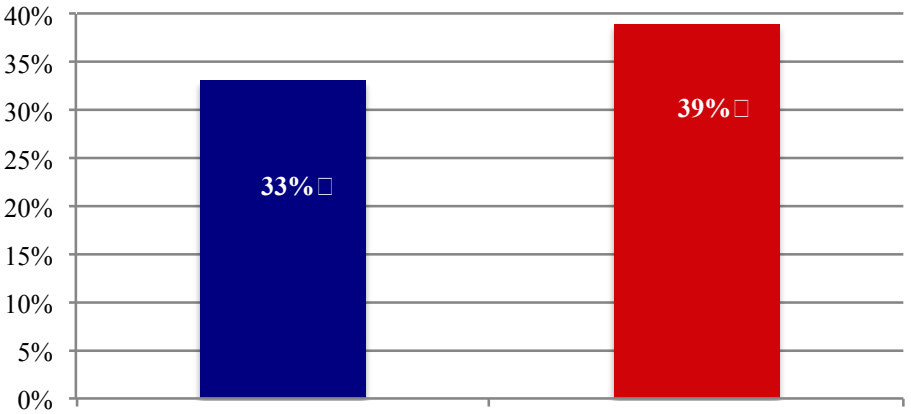
Data: TennCare, Calculations: own

The proportion of the most costly TennCare patients is not significantly different for urban and rural counties. These proportions are similar to the entire TennCare population, in which 73.7 percent of patients are in urban counties and 26.3 percent are in rural counties.[48] The fact that the highest cost TennCare patients are distributed between urban and rural counties to a similar extent as the overall TennCare population suggests that focusing only on urban practices will be insufficient in addressing the challenges of high-cost patients. Moreover, given that more than one quarter of high-cost patients live in rural counties, overall TennCare cost challenges are not likely to be addressed with an exclusively urban reform focus.

Average spending in urban vs. rural counties is only slightly different among the top 5 percent most expensive patients, largely due to the presence of very high-cost outlier patients in urban counties. Age and health status* are also similar for urban and rural counties; however, there is a higher percentage of high-cost patients in rural counties that have two or more chronic conditions. At the same time, PMPM spending is lower in rural areas (as seen in Table 1), suggesting that the high costs in urban areas may be correlated with factors besides health status and chronic conditions. This will be particularly important for providers who are acting as quarterbacks for episodes of care, many of whom will be treating these high-cost patients with chronic conditions. The patient-level data shows that addressing the challenges around these high-cost and potentially chronically ill patient populations will need to be considered in both rural and urban settings, as each faces factors besides health status that are driving costs.

* Health status is categorized as: healthy, catastrophic, dominant chronic disease in three or more organs, dominant/metastatic malignancy, history of significant acute disease, minor chronic diseases in multiple organs, significant chronic disease, significant chronic diseases in multiple organs, and single minor chronic disease.

Figure 3: Percent of TennCare Patients With Two or More Chronic Diseases



Data: TennCare, Calculations: own

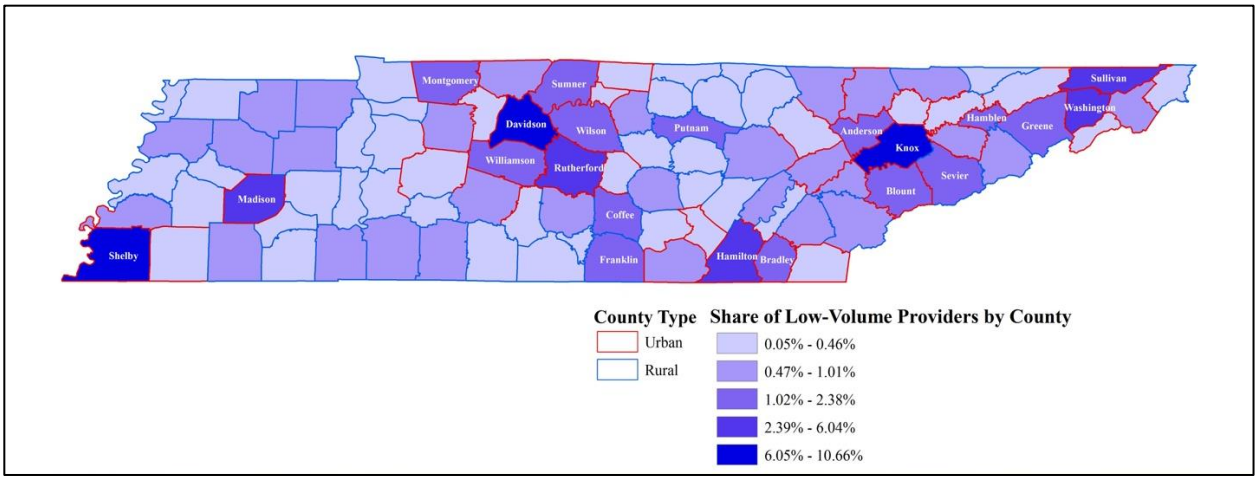
Mapping: Cost and Geography

By mapping the data provided by TennCare, it is possible to show several important additional trends that help to highlight the distribution of providers and TennCare spending throughout Tennessee.

Low-Volume Providers by County

A visual representation of the share of low-volume providers by county reflects, as previously discussed, that large urban centers also have a high number of low-volume TennCare providers. The distribution of low-volume practices shown in Map 1 below largely mirrors the geographic distribution of TennCare costs and patients. This suggests that where there are more TennCare patients, there are more TennCare providers with both low-volume and high-volume TennCare panels.

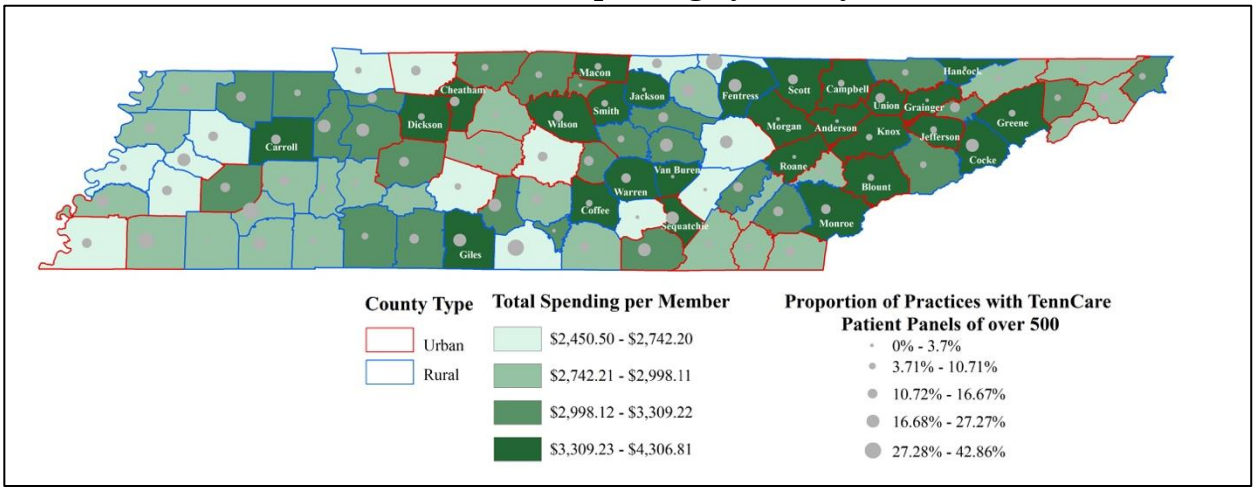
Map 1: Number of Low-Volume Providers by County



Practice Size Distribution within Counties

The distribution of practice size by county, as graphically illustrated in Map 2 below, further bolsters the evidence that there are not clear divisions between urban and rural counties with regard to the proportion of practices with low-volume TennCare patient panels. It is clear that many rural areas actually have a higher percentage of practices with larger TennCare panels, while many urban counties have a lower percentage of such practices.

Map 2: Proportion of Low-Volume Providers and Per-Member Spending by County

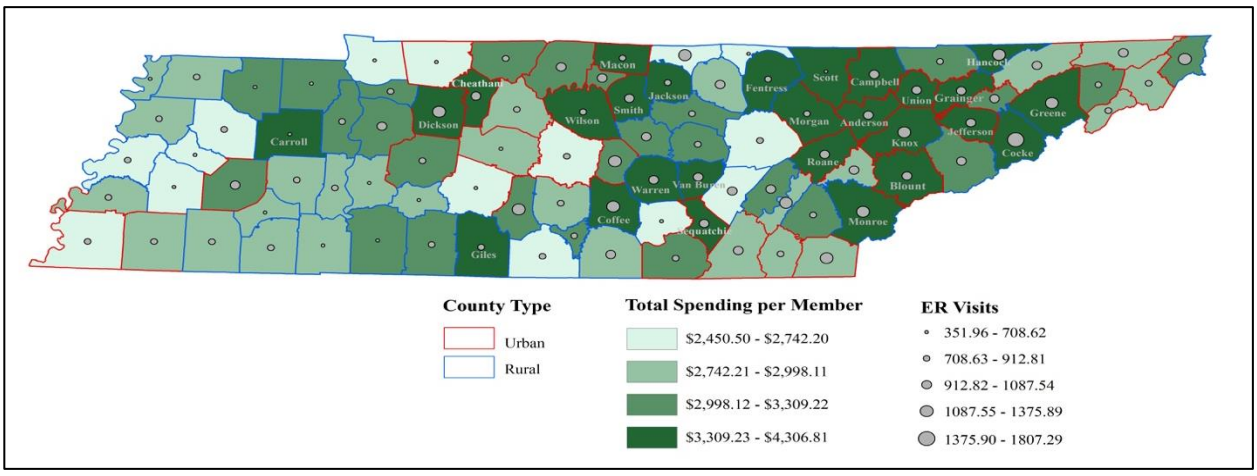


Per-Member Spending and ER Admissions by County

There appear to be some geographic trends regarding per-member spending; for example, the northeast region of the state has a greater concentration of counties with high per-member spending compared to other regions.

However, high per-member spending is not always correlated with a county's urban or rural status. As Map 3 below indicates, 10 rural counties still demonstrate per-member spending above $3,309 a year. Interestingly, there does not appear to be a clear correlation between emergency room (ER) visits per thousand and high per-member spending at the county level.

Map 3: Per-Member Spending and ER Admits by County

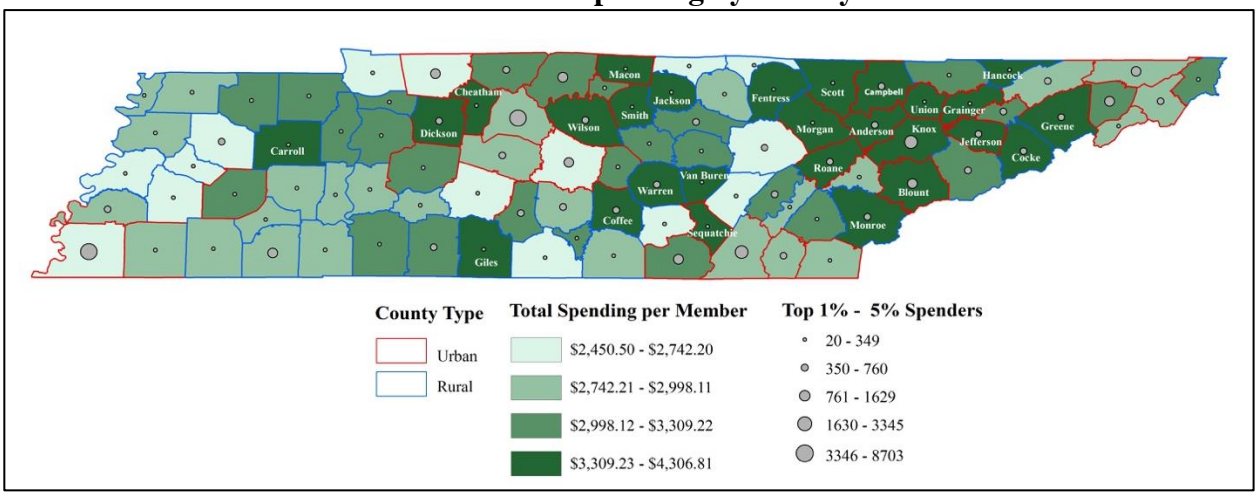


Concentration of High-Cost Patients by County

Another important finding suggests that whether a county has a high number of high-cost patients is not correlated with whether it has high per-member spending. It is not clear from the data why this would be the case. It is possible that areas with large numbers of the highest-cost patients simply have greater patient loads overall, so that the costs are more easily spread across the population. However, it could also show that some areas are able to better control costs across the population despite a concentration of high-cost patients.

While we do not have practice-level data on episodes nor specific information on the conditions these high-cost patients have, we can assume that at least one or more of their chronic conditions will be affected by an episode of care. Since these patients are spread out across urban and rural counties, excluding certain types of providers based on geographic location may not be the best way to account for the challenges faced by low-volume providers in implementing episodes of care.

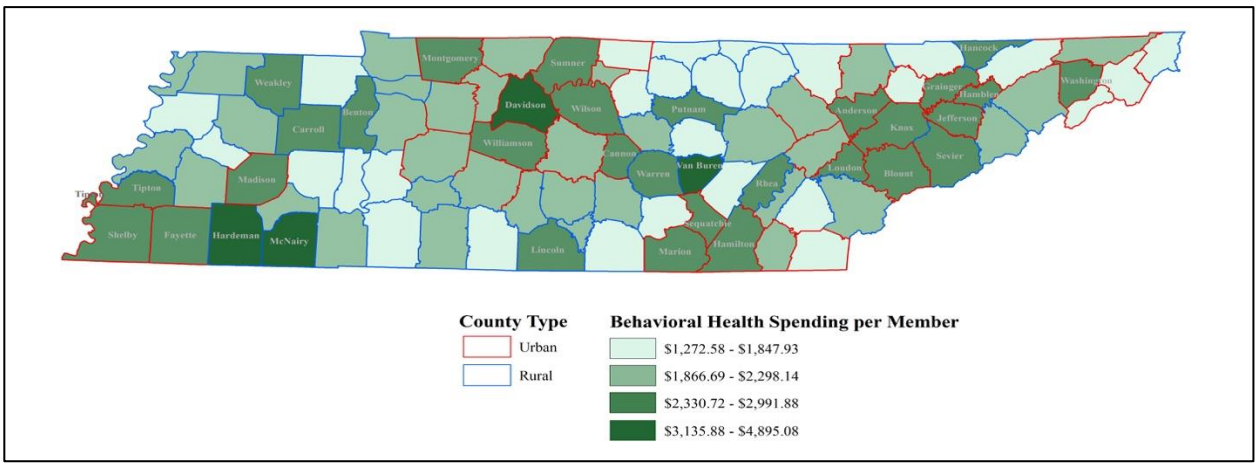
Map 4: Number of Top-5-Percent-Spending-Patients and Per-Member Spending by County



Behavioral Health Spending by County

Behavioral health spending does appear to have some correlation between urban counties and higher per-member-per-month behavioral health spending, but there are some significant exceptions. For example, Shelby County, with the state's largest urban center, Memphis, has lower per-member behavioral health spending than nearby rural McNair County. A general shortage of behavioral health providers suggests that per-member spending may indicate the availability of behavioral health services more than need or unnecessarily high costs, although it is not clear from the data if this is the case.

Map 5: Per-Member Behavioral Health Spending by County



Together, the geographic trends depicted in these maps suggest that there are few clear broad differences in TennCare patient costs between urban and rural counties. However, the data does indicate that there is a greater concentration of low-volume providers in major metropolitan areas and that these providers have higher per-member costs, which has implications for implementing TennCare's reforms.

Part I: Patient-Centered Medical Homes

Patient-Centered Medical Homes

Patient-Centered Medical Home (PCMH) programs, such as the one proposed as part of the Tennessee Healthcare Innovation Initiative, have been adopted in a variety of forms across the country.[49] In addition to the promise of improved care quality, a PCMH is attractive to primary care providers because it offers a new revenue stream for care coordination efforts.[50] The PCMH model also rarely includes downside payment risk, making its implementation less threatening to many practices than other payment reform models. The PCMH program proposed as part of the Tennessee Healthcare Innovation Initiative already adheres to many best practices articulated in the substantial literature on PCMH models, including payment for up-front practice transformation, a separate per-member-per-month (PMPM) payment for new clinical activities, and PMPM payments adjusted for patient acuity.[51] Stakeholder support for the PCMH initiative was strong among those interviewed for this report, due in part to all of the positive program designs.[52]

Despite a general lack of resistance to the initiative, TennCare's PCMH program faces several challenges for attracting low-volume providers into the optional program. These challenges affect five aspects of the program's design: (1) payment structure, (2) eligibility and reporting requirements, (3) practice resources pooling, (4) behavioral health integration needs, and (5) education and outreach. The assessment below discusses the challenges affecting each of these areas of program design, outlines best practices from academic literature and other states, and provides policy recommendations. A discussion of provider education and outreach is outlined in a separate section relating to both the PCMH and episodes of care initiatives.

Payment Structure

Introduction

The PCMH payment structure serves as a critical leverage point for convincing individual providers to participate in the program. For low-volume practices facing capacity challenges that might otherwise dissuade participation, the payment structure provides an opportunity to tip the scales toward interest in participation. It also provides an opportunity to focus on the "carrot," the incentives of the program. This section examines two areas where the current PCMH program's payment structure could be adjusted to increase participation by low-volume providers: (1) payment stability and (2) outcomes-based payments.

Challenges

Payment Predictability and Stability

Payment stability and predictability is a crucial factor for physician satisfaction, especially among low-volume providers with small margins. Income stability bears an even greater salience than level of income.[53] It is not surprising that small-practice physicians expressed concerns about how delivery and payment reforms might affect income predictability and their effect on practice sustainability.[54]

A survey of nearly 700 physicians across the country indicated that, in addition to general apprehension surrounding these uncertainties, providers expressed concerns that "the transition from one payment model (fee-for-service) to a new payment model (e.g., shared savings or capitation) would be complicated, with physicians receiving mixed incentives from different payers."[55] Research has also suggested that "transitions between payment models will be smoothest if incomes can be stabilized even as incentives change."[56] The stability of a floor for minimum payment to providers is critical. As the manager of one multi-specialty practice stated:

> If you can figure out how to pay doctors a market-based salary while changing what they're doing, and it feels safe to them, then they are going to be the crucial movers to value...We put a floor in on our physician salary such that their income with all this investment would not drop below a certain level.[57]

Specifically, certainty of payment level in the PCMH model will be a critical factor in whether a practice will decide to pursue PCMH certification under the program. A paper from the Center for Studying Health Policy Change at Mathematica Policy Research made the following observation:

> Physicians will judge proposed payment levels based on whether they are high enough to amortize investment costs and cover operating costs of new medical-home capabilities... physicians' interest in participating may depend on whether they believe that payments exceed their likely operating costs by a large enough margin to offset their investment costs.[58]

This framework suggests setting a minimum PMPM payment will be critical and provides a structure for setting it for providers of different sizes.

Setting a minimum PMPM payment across all MCOs maintains an important consistency among payers. The Mathematica report also noted that understanding how physicians will respond to payment levels requires considering the portion of practice revenue that their patient panel-based payments represent.[59] Most PCMH programs are single-payer-based, so that the covered patient panel is only a small portion of a practice's overall patient panel.[60] Splintering PMPM payment rates between different MCOs within Medicaid will mean each rate applies to a small fraction of a physician's patient panel and will drive down provider participation.

Economies of Scale

Low-volume practices do not experience the economies of scale enjoyed by larger providers, and will be less likely to participate at lower payment rates. This is true regardless of the geographic location of the low-volume practice. When the total patient panels for a physician practice are small, the fixed costs from staff and equipment for care coordination efforts can be prohibitive until there are enough patients to benefit from the minimum investment in these resources. Investing in a care management staff position or Electronic Health Record (EHR) upgrade may not pay off until a practice has a larger patient panel size. This suggests that panel size should be a key consideration in setting PMPM payments. The correlation between panel size and costs that this report found bolsters this conclusion, although there remain important reasons to consider geography as well, given the general lack of resources in many rural counties.

Health Information Technology and Electronic Health Records

Low-volume practices face greater gaps in health information technology (HIT) and EHR capability, and some may lack an EHR system entirely. This is particularly true for more isolated and rural low-volume practices, which account for some – though not all – of the low-volume practices in TennCare. A recent report focusing on Rural Health Clinics (RHCs), for example, noted that "insufficient health information technology capacity in primary care settings," common in rural environments, is a major barrier to the adoption of PCMH models.[61] As a recent report from the National Quality Forum (NQF) stated, this may be due to the fact that rural areas have a "limited supply" of individuals with specialized skills, including technological and quality improvement proficiencies, which are necessary to implement measurement programs.[62] In one example of this capacity gap, only 121 of the 203 RHCs that responded to a recent survey had adopted EHR systems.[63] The TennCare PCMH proposal does not require EHR adoption, but the functions required for certification would be far more easily accomplished with EHR systems.[64]

Cost-Based Outcomes Payments

Outcomes measures based on total cost of care are not often achieved in the first year of PCMH implementation.[65] Some utilization trends might actually increase overall costs in the first year as patients receive needed additional primary care and outpatient services, and as practices absorb other practice-transformation costs.[66] A meta-assessment of PCMH evaluations by the Agency for Healthcare Research and Quality (AHRQ) recommends following outcomes for longer periods of time.[67] This may be less of a concern for reductions in Emergency Department (ED) utilization, which some analyses found were impacted in the first year.[68] However, in some cases ED utilization changes can dissipate over time.[69] This raises some concerns about including a shared savings or other utilization-based outcome payment in the first year of the program as the current TennCare PCMH proposal does.

Best Practices

Payment Predictability and Stability

Balancing the need of providers for payment certainty and stability with the ability of payers to differentiate their managed care plans is critical. One way of doing this is by setting "guardrails" on PMPM payments. This requires setting dollar figures for the ranges that PMPM payments could fall between. Literature assessing the challenges and best practices for multi-payer PCMH models suggests providing ranges of PMPMs as a means of creating payment certainty, or at least setting a minimum payment for providers while allowing some amount of differentiation.[70] There is currently a wide range of approaches being used across the country. Some programs, like New York's Adirondack's Medical Home Demonstration, set a universal PMPM payment ($7), while Idaho, which allows significant variation in PMPM payments between payers, has a range from $15 to $42.[71] Arkansas has set their PMPM payment at $4, with an additional $1 PMPM payment for practice transformation that is paid to a technical support vendor.[72]

Cost-Based Outcomes Payments

Other states have delayed portions of their cost and utilization-based payments. Maryland, for example, delayed its payments to practices that achieve targeted thresholds until the second year of the program.[73] It did, however, let providers share in savings in the first year. In New York,

the Capital District PCMH program delayed all of its bonus payments until the second year of the program.[74]

Key Points & Recommendations

This report makes two recommendations for the PCMH payment model to improve uptake among low-volume practices.

- ☑ **Consider setting a PMPM payment range.** TennCare should consider setting a specific range for the new clinical activities PMPM payments that MCOs will pay to PCMH-certified practices. By setting a PMPM payment range with specific dollar figures, the state can guarantee a minimum payment amount that providers can rely on to reduce uncertainty for practices. The PMPM payment range should take into consideration economies of scale challenges and HIT infrastructure needs of low-volume providers.

- ☑ **Consider delaying cost-based outcomes payments.** Outcomes assessments of other PCMH models found that cost savings often take more than a year to be realized. Delaying cost-based outcomes payments until the second year of the PCMH program will allow time for the PCMH practice changes to be fully adopted.

Eligibility and Reporting Requirements

Introduction

The current certification and reporting requirements of the PCMH model also warrant consideration. There are two related challenges that low-volume providers face: (1) variations in program requirements between payers, and (2) the size at which a practice is simply too small to successfully adopt the PCMH model on its own. For low-volume providers, these issues can dramatically hamper uptake of the PCMH model. This analysis does not target specific requirements for elimination or revision; rather, it considers broad-based changes that might be considered. The focus is not on lowering the standards for certification and reporting, but rather on ways that the initiative can increase uptake through greater consistency.

Challenges

Variation Between Payers

Variation in PCMH eligibility and reporting requirements between payers (MCOs) can be a significant impediment to uptake, especially for low-volume practices. For example, requiring additional quality measures for reporting under one MCO's PCMH program that do not apply to another MCO's PCMH program creates confusion and can significantly disrupt practice workflow under the new care delivery model. While allowing for some flexibility on PMPMs between payers can be feasible, any variation on other program design features such as practice qualification standards and reporting metrics is immensely problematic for providers.[75] Variation across payers of these programmatic features could create a major disincentive for practices to participate.

This dynamic can be exacerbated for a low-volume practice if it already has limited administrative capacity. Consequently, complying with varying qualification standards or reporting requirements would pose an even greater challenge. As a recent NQF report on quality measurement for low-volume rural providers described: "Lack of alignment in quality measurement was one of the key challenges for rural providers that was identified by the committee. Accordingly, the Committee strongly recommends continued efforts to align both measures and data collection efforts."[76]

Minimum Panel Size

Under a certain patient panel size, PMPM payments for new clinical activities will not be sufficient to support necessary staffing and administrative needs. This challenge is related to the lack of economies of scale for low-volume providers. For practices with small enough panel sizes, the PMPM payment will simply not be enough to cover their necessary investments in care coordination capacity. Consider the following hypothetical examples, which use a middle point of $4.75 for the PMPM rate, based on an analysis of 26 PCMH models that found a PMPM range of $0.50 to $9.[77]

> *Practice with a 2,000-member patient panel:* Assuming a $4.75 PMPM, the practice would receive $114,000 a year—enough to invest in care coordination and data analyst staff, as well as possibly staff trainings.

Practice with a 100-member patient panel: Again assuming a $4.75 PMPM, the practice would receive only $5,700 a year—not enough to support even a single care coordinator staff position.

Between these two examples lies a likely minimum panel size, but determining that level in a manner that does not preclude the participation of all low-volume providers is a significant challenge. The current PCMH program sets a minimum panel size for an individual practice at 500 patients from one MCO.

One strategy to ameliorate some of the resource constraints for smaller practices came out of a PCMH Technical Advisory Group discussion. Sharing a client care coordinator is a way for smaller providers to achieve eligibility and learn best practices for care management.[78]

Best Practices

Variation Between Payers

There are several examples of states that have set unified standards for multi-payer PCMH models. The Pennsylvania Department of Health created a single set of participation standards in their PCMH model for both payers and providers.[79] In Washington, there were two components to the standards for the PCMH model: (1) an informal agreement between the different payers and the health department, and (2) the creation of a template for contract agreements among the payers.[80] Ohio also made an effort to bring all payers to the table in developing their common quality metrics.[81]

Minimum Panel Size

Nationally, PCMH patient panel sizes vary dramatically. One recent report cited PCMH patient panels per physician that ranged from 1,000 to 2,400.[82] An Advisory Board Company report suggested that the average PCMH patient panel per physician was 1,958. There are also some examples of states setting minimum panel sizes for PCMH programs.[83] Arkansas's PCMH model, developed in 2013, set a minimum Medicaid patient panel of 300 for a practice to become certified as a PCMH under the program.[84] At this size, however, practices are unlikely to be able to sufficiently cover their care management costs. Below a minimum panel size, practices might be able to pool resources to sufficiently cover their costs. Both North Carolina and Rhode Island have pursued this type of model.

Key Points & Recommendations

This report provides two recommendations for the eligibility and reporting requirements.

- ☑ **Consider standardizing eligibility and reporting requirements.** TennCare should consider making PCMH eligibility and reporting requirements, as well as risk adjustments, uniform, or nearly uniform, across MCOs. TennCare should consider limiting MCOs' ability to place additional certification and reporting requirements on PCMH practices above what the state requires. The program should seek to have providers experience the PCMH certification and reporting requirements as one single

program that is administered through multiple MCOs. Any variation on these requirements creates significant barriers to uptake and should be avoided. The more consistency is maintained across payers, the more practices will be willing to engage the program.

☑ **Consider setting a minimum panel size.** TennCare should consider setting a minimum panel size for PCMH certification, based on the extent to which the PMPM payment for new clinical activities will enable practices to afford acquiring the necessary care coordination staff and practice supports. TennCare could consider calculating the minimum panel size based on a practice's total PCMH enrollment, provided it does not place undue administrative burden on the program or carriers. Below the minimum panel size, practices would have to form resource pooling arangments with others that allow them to meet this threshold together. The minimum panel size would be dependent on the estimated costs for care coordination staff and other practice supports. While specific pricing information for these inputs would be needed to appropriately set the panel size, TennCare may want to consider a decision matrix that adheres to the following structure:

New Clinical Activities PMPM x TennCare patient panel size = sufficient funding for one full time (or two part-time) care coordination staff + data analysis and administrative staff time and training.

Example:[†]

$4.75 PMPM x 1000 TennCare patients = $57,000 annually

- One full-time coordinator staff = $38,000
- Part-time data analytics staff = $14,000
- Administrative and Behavioral Health Staff Training = $5,000.

[†] Estimated practice costs are purely speculative for this example.

Practice Resource Pooling

Introduction

Research and conversations with Tennessee stakeholders suggest that low-volume providers do not typically possess the resources, staff, or infrastructure necessary to implement and utilize key health information technology (HIT) tools. By providing incentives to consolidate smaller practices into larger networks, both state-led and private-public partnerships have created solutions to ease the adoption of HIT tools among low-volume providers. We recommend that TennCare consider resource-pooling designs that reflect best practices and that could successfully allow smaller practices to achieve greater use of HIT tools and participate in the PCMH initiative. The provision of both practice- and network-specific support services would enable providers to acquire and maintain the HIT tools necessary to interpret data, adjust health care delivery practices, and manage patient care.

Challenges

Low-volume providers, with limited staff and resources, face significant challenges when implementing the key components of the PCMH model.[85] A primary principle of the PCMH model is the use of HIT tools to coordinate and integrate care across all elements of the health care system and community.[86] HIT tools, such as electronic health records (EHRs), patient registries, and electronic prescribing, are costly and time intensive for low-volume providers to implement.[87] Stakeholders identified that low-volume providers do not have the basic infrastructure required to implement HIT tools.[88] Some barriers to HIT adoption may even include broadband access, which is necessary for electronically sharing any information between individual providers, in some particularly isolated rural areas.[89]

Low-volume providers also face inadequate data measurements and capabilities, which further jeopardize their ability to successfully adopt HIT tools. As a result, low-volume providers are not able to effectively utilize HIT tools, which, consequently, impacts their ability to participate in the PCMH model. In addition to panel-size challenges, Tennessee stakeholders identified a lack of staff capable of analyzing data as another considerable obstacle.[90] While large establishments have the resources to maintain an analytics department, small practices do not have the type of personnel necessary to analyze patient panels. A study found that high-resourced PCMHs were making considerable investments in their HIT infrastructures, including building data depositories, developing condition-based registries, and inventing algorithms to identify high-risk patients.[91]

At the same time, low-volume practices face higher per-member costs, as the analysis in this report found, and the vast majority of practices—nearly 90 percent—have total TennCare patient panel sizes of less than 500.[92] The only way for those practices that will likely not meet minimum panel size requirements to participate in the PCMH program is to pool resources.

Best Practices

To address the complex challenges surrounding the implementation and utilization of HIT tools among low-volume providers, this analysis examines best practices that have been implemented in Tennessee, Vermont, and North Carolina. In each of these models, smaller practices consolidated into larger entities in an effort to address low-volume providers' concerns.

Cumberland Center for Healthcare Innovation (CCHI)

CCHI, which is currently participating in the Medicare Shared Savings program as an Accountable Care Organization (ACO), is comprised of 28 rural independent practices across 14 counties in central Tennessee and is physician-led.[93] By leveraging data analytics, CCHI is working to better manage patient care and workflow. CCHI supports low-volume providers in overcoming barriers related to a lack of infrastructure, IT literacy among staff, and resources. As with many information exchanges, claims and EHR data are heavily relied upon. CCHI uses clinical data analytics technology to pull data from 14 different EHR systems. The clinical data analytics technology is also capable of data mining, predictive modeling, and business intelligence, further improving staff performance and process effectiveness.[94]

CCHI resolved barriers to HIT implementation and utilization among low-volume providers in the following three ways. First, by choosing a clinical data analytics technology that enables the integration of any EHR application, CCHI saved considerable infrastructure costs by avoiding upgrading to a uniform EHR system across all of its independent practices. Second, CCHI's clinical data analytic technology is user-friendly, requiring only minimal technical skills to interpret the data.[95] Lastly, the clinical data analytic technology enables users to run their own reports, freeing clinicians from relying on IT staff to generate practice-specific reports. As a result, small practices are able to participate in CCHI's model of care. It is worth noting that the decision to layer a data-analytic interface on top of the different EHRs used by practices was an extension of a critical broader theme voiced by CCHI of emphasizing the independence of each practice, while also enabling the sharing of cost and quality data between them.

Vermont Blueprint for Health

The Blueprint for Health (Blueprint) is Vermont's state-led initiative charged with integrating "a system of health care for patients, improving the health of the overall population, and improving control over health care costs by promoting health maintenance, prevention, and care coordination and management."[96] Among other reforms, such as payment modifications, Blueprint has worked with stakeholders across the state to implement HIT and support health information exchange. Blueprint has 14 health service areas in the state, where 124 PCMHs manage the care of more than 500,000 patients.[97]

A key Blueprint initiative is the formation of provider networks, formal business arrangements of previously independent providers. This initiative aims to enhance the use of data to guide service and quality improvement. Blueprint and provider networks are co-producing performance dashboards featuring provider-network-measure results, as well as other important analytics.[98] These dashboards present population-level results, directly addressing low-volume providers' small-panel-size obstacle.

In addition to addressing the data measurement challenge, Blueprint helps providers overcome staffing challenges. To this end, Blueprint employs a team of IT staff (known as "Sprints") across organizations to ensure accurate, timely, and reliable data extraction, transmission, and registry reporting. In particular, Sprints projects resolve data quality issues for existing interfaces and repositories, and data cleanup prior to incorporating the practice into the state's health information exchange.[99] By providing support services to resolve small-panel and staffing obstacles, Blueprint helps low-volume providers implement and utilize HIT tools.

Community Care of North Carolina (CCNC)

CCNC is a public-private partnership of networks of primary care physicians, hospitals, health departments, and social service organizations. CCNC has approximately 4,200 primary care physicians across 14 networks. Each network has a clinical director, network director, PharmD, psychiatrist, and care managers. CCNC connects organizations to provide and manage care for more than one million Medicaid enrollees.[100]

To ensure that networks and providers have access to performance data and analysis, CCNC developed an Informatics Center, an electronic data exchange infrastructure that provides quality and care management data to networks and practices. The Informatics Center receives data from various sources, including EHRs, real-time hospital and pharmacy information, pharmacist and case manager input, pharmacy and medical claims, and lab results. Networks use the data to monitor quality of care and provide performance feedback at the patient, practice, and network level. In reference to the importance of the Informatics Center, CCNC states, "While obtaining timely and meaningful data is never easy, it is nearly impossible for local providers and networks to do so on their own."[101] Through collecting, studying, and distributing this information, CCNC supports low-volume providers in overcoming challenges related to small panel sizes.

CCNC also helps providers overcome affordability, staffing, and infrastructure barriers. At the development stage, CCNC provided its networks with approximately $30,000 in start-up funds to support infrastructure, staffing, and other initial expenses.[102] Furthermore, a considerable proportion of CCNC staff is devoted to offering analytical support to providers and networks.[103] This support offsets low-volume providers' difficulty in interpreting the data. Lastly, CCNC provides legal support. Given the exchange of enrollee data, CCNC offers practices and networks a provider agreement that protects the exchange of personal health information.[104] CCNC states, "As the area of health data exchange is complicated and ever-changing, our reliance on legal counsel was costly but absolutely crucial."[105] Through providing various support services, ranging from the creation of a health information exchange and funds to cover initial infrastructure improvements to ongoing technical and legal assistance, CCNC created solutions to ease the adoption of HIT tools among low-volume providers.

Key Points & Recommendations

This report provides two recommendations for enabling practices to pool resources, and to provide practice supports across practice settings.

- ☑ **Enable pooling of resources across smaller practices.** TennCare is considering three approaches to pooling: (1) pool across practices, (2) pool across TennCare MCOs, and

(3) pool across lines of business. Given the association between HIT use and practice size, we recommend that TennCare consider pooling across practices to increase adoption of PCMH processes. The pooling of smaller practices into a larger network should be an opt-in initiative in an effort to foster physician-led networks.

☑ **Explore providing additional practice-specific short-run support and network-specific long-run support.** While TennCare is already developing a Care Coordination Tool to enable information sharing among providers, it may also want to consider additional practice supports. At the practice level, TennCare should consider providing IT-related infrastructure improvements including supporting broadband access in some cases, data-related training and coaching, and sample legal agreements. This short-run assistance should be personalized to meet the needs of each practice, further incentivizing providers to participate in the pooling. At the network level, TennCare should consider providing clinical data analytic technology, centralized data analytic staff, and possibly regional care coordination staff shared between practices. The data analytic technology is in line with, and should build on, the shared Care Coordination Tool already being developed by TennCare, though additional capacity for interfacing with multiple EHR systems and the ability to track cost and quality data across practices would also be critical. These long-run support services could be funded by TennCare and shared among practices within a particular network, ensuring that low-volume providers have the HIT tools necessary to interpret data, adjust health care delivery practices, and manage patient care going forward.

Behavioral Health Integration

Introduction

For the PCMH initiative to be successful, it will have to control costs and improve outcomes for the highest cost patients who often have co-occurring physical and behavioral health conditions. In TennCare, 64 percent of the top 5 percent of highest-cost patients have a behavioral health diagnosis and receive care, a rate more than three times higher than for the rest of the TennCare patient population.[106] Those with behavioral health needs make up only 20 percent of the overall patient population, but account for 39 percent of spending.[107] While the Health Home initiative focuses specifically on the TennCare patient population with severe and persistent mental illness (SPMI), other high-cost patients may be more connected to their traditional primary care provider. Primary care providers (PCPs) have often served as a gateway for individuals with both behavioral health (BH) and primary care needs. For these individuals, ensuring that there is behavioral health integration within PCMH-certified practices is critical.

This section addresses the challenges of ensuring behavioral health integration at PCMH-certified practices, particularly low-volume practices that are less likely to have the necessary capacities.

Challenges

A fully integrated primary care and behavioral health model generally incorporates the following resources for services required by patients with behavioral health conditions:

1. Universal screening for behavioral health issues, including substance and alcohol abuse;
2. Self-management support and brief interventions by a behaviorist;
3. Treatment of the behavioral health condition by the care team; and
4. Appropriate referral for treatment to a psychologist or psychiatrist, as warranted.[108]

Unfortunately, low-volume primary care providers, or those in rural areas, are often the least likely to have the behavioral health capacity to implement behavioral health integration. The data analysis in this report suggested some correlation between rural communities and lower per-member behavioral health spending that might best be understood as a sign of limited access to such services. In this case, there may be both a practice size and geographic component to the varying degrees of behavioral health capacity.

One reason for the lack of behavioral health capacity among all providers, which may be most acutely felt by low-volume and rural providers, is related to the unique way that behavioral health is reimbursed under many Medicaid programs. As the medical director for Cherokee Health noted, “carved out” funding streams and obscure health insurance payment rules present a significant challenge.[109] Because behavioral health billing is essentially a time-based system, there are only a few codes for such services, and payers will only reimburse for one service per day. In an integrated environment, such rigid payment structures can create disincentives for including the work of a behaviorist or referrals to behavioral health providers when they are needed. There is also an additional challenge related to the fact that any consultation not

conducted as a face-to-face visit is not readily reimbursable under traditional fee-for-service payment structures. In combination, these dynamics make it difficult for small practices to fund the full range of expertise they require to effectively transition to an integrated model and serve patients with complex needs. For these reasons, smaller practices will likely require additional resources to devote extra time to new patients with both behavioral and physical needs, as well as address new comprehensive requirements for existing patients.

Best Practices

There are wide ranges of successful models for integrating primary and behavioral health care. These include the use of care managers, behavioral health consultants, or behaviorists with the aim of improving patient experience, emphasizing prevention and disease management, and reducing hospitalization rates and emergency department visits. These practices ultimately increase savings per patient and improve quality of care. Studies have also shown that many of the models have been successful in reducing income-based disparities in care, as well as provider burnout.[110] Exemplary practices include the following:

- Fully integrated staff working as a multi-disciplinary care team, whereby colocation of both BH and PCPs working for the same organization ensures warm handoffs and facilitates access.[111]
- A purposefully designed co-location model where staff members from various partnering organizations collaborate in the care of individuals.[112]
- Tele-health services supporting the primary care team.
- Arrangements for patients with severe behavioral health issues, whereby BH organizations serve as the individual's Health Home, but work with a primary care team to address issues of physical health and prevention for that particular patient.[113]
- Informal mechanisms and strategies to help practices—particularly small practices—achieve important aspects of the integrated PCMH model.[114,]

The main lesson in analyzing these different models is that one size does not fit all. Successful mergers have employed a variety of integration models depending on the payment environment. However, all practices, and especially low-volume practices, will likely require additional resources to support their integrated care model, in whatever form it takes. CSI Solutions, a health care consulting firm, devised a basic business model to help practices with these challenges, and it is relevant here in determining appropriate payment levels. The premise behind this basic business case formula is that for any service, cost is less than revenue. In the case of BH integration into PC, it translates to the following:

Cost of Screening (S) + Cost of Intervention Services (I) + Transition Costs (T)

must be less than or equal to

Screening Reimbursement (X) + Productivity Gains (P) + Treatment Reimbursement (R)

summarized as follows:

$S+I+T \leq X+P+R$

Key Points & Recommendations

The following recommendations would enable TennCare to encourage the building of behavioral health capacity at PCMH-certified practices to more effectively treat high-risk patients with co-occurring behavioral health conditions.

- ☑ **Consider building in payments to support behavioral health capacity at PCMH practices.** TennCare should consider building an assumption into the New Clinical Activities payment that this payment should also cover the cost of an embedded behavioral health professional. This would result in a higher PMPM. For practices above a certain patient panel size, the payment could be made directly to a practice for hiring its own behavioral health staff. For practices below the minimum patient panel size, the payment could be used to support a behavioral health professional that could be shared among multiple practices as part of the pooled resources structure. Tele-health consultations could also be considered for inclusion in the payment.

- ☑ **Consider including a behavioral health integration measure as an outcomes-based payment metric.** TennCare could consider including a behavioral health integration measure, such as substance use screening reporting, as an additional criterion in the outcomes-based payments alongside the current total cost of care (TCOC) measures. The reporting of such a measure could either be required to receive the outcomes-based payment, or it could result in a bonus payment.

- ☑ **Encourage the formation of formal arrangements between PCMH-certified practices and local behavioral health professionals.** TennCare could consider encouraging PCMH-certified practices to form stronger formal relationships with behavioral health professionals, including community mental health centers, to enable easier patient referrals and better integration of services. One way to do this would be to add behavioral health referral rates to the PCMH reporting requirements, though likely not until later years of the initiative, or as an optional reporting measure.

Part II: Episodes of Care

Episodes of Care

TennCare is rolling out a mandatory retrospective episodes-of-care payment model that began its first performance period in calendar year 2015. Under the initiative a primary accountable provider (PAP), or quarterback, is responsible for coordinating a patient's care across the episode. The first three "episodes"—acute asthma exacerbation, perinatal, and total joint replacement—were areas of high spending for TennCare and the commercial side of TennCare's MCOs. In summer 2016, physicians will be eligible for reward payments or owe risk-sharing penalties to the MCOs. TennCare is expecting to design and implement 75 episodes by 2020 in areas that affect both TennCare and commercial patients.

This report does not include an analysis of episode-level data, but the data analysis of the highest-cost TennCare patients suggests that these patients suffer from multiple chronic conditions. The challenges around these high-cost and potentially chronically ill patient populations will need to be addressed in both urban and rural settings, as they are represented proportionately in both regions. The practice and patient data evaluated earlier also suggest that factors besides health status are driving cost differences between rural and urban low-volume providers. Whether this difference is attributed to non-health differences in the two populations, provider practice, or other factors will also be of concern for payers and providers as episodes of care are implemented. Greater clarity regarding the underlying causes of these differences would be valuable, but would require additional data.

TennCare's episode model faces several challenges for engaging low-volume providers in the mandatory program. These challenges affect three aspects of the program's design: (1) risk-adjustment formulas, (2) downside risk, and (3) data reports provided to PAPs, or quarterbacks. The assessment below discusses the challenges affecting each of these areas of program design, outlines best practices from academic literature and other states for addressing such challenges, and provides policy recommendations for mitigating them.

Non-Alignment of MCO Risk-Adjustment Formulas

Introduction

An episode of care measures the overall cost of treating a patient for a specific condition or service by defining the scope of that condition, assigning responsibility for that episode to one type of provider, and then comparing the overall cost of treatment with a benchmark to determine the shared savings for lower-than-average costs or penalty fees for significantly higher-than-average costs.[115] Before being compared to the benchmark, the cost of care is risk adjusted according to patient characteristics that drive expected costs to be higher or lower than they would be for the typical patient. [116]

There are several reasons risk adjustment is important to any payment reform in which providers take on some level of risk, including the episodes of care initiative. First, adjustment for patient risk is intended to remove factors beyond the control of the physicians that increase the cost of treatment.[117] Appropriate risk adjustment is critical for payment reforms because without it,

"physicians probably will not accept the data as credible."[118] Second, risk adjustment is a means to protect the access to care of all patients by removing the incentive for physicians to discriminate against complex patients who are likely expensive to treat.[119]

Challenges

Currently, Tennessee has not standardized the risk-adjustment formula for TennCare's episodes of care model. Instead the risk-adjustment method is decided individually by each of the three MCOs.[120] Consequently, identical treatments for an identical patient could generate different levels of shared-savings reward or penalty payments for a practice, depending on which MCO covers that patient. This variation may lead to conflicting signals, complicating the ability of a provider to respond or potentially even incentivizing the provider to select patients based on their MCO coverage. However, two of the three MCOs currently use the same risk-adjustment formulas, suggesting that standardizing across the three may be feasible.[121]

Best Practices

The precedent of aligning risk-adjustment formulas has already been set by episodes of care reform in other states. Through working groups, Arkansas has designed risk-adjustment methodology for each episode so that, "with the exception of payment and threshold rates (which vary a bit by payer), most methodology surrounding episode design and implementation is aligned across participating payers."[122] Moreover, Arkansas has implemented episodes of care reform across multiple payers, including both Medicaid and self-insured payers.[123] Similarly, in Ohio, the Medicaid fee-for-service plan and all five Medicaid managed care plans are using the same definitions and formulas to implement episodes of care.[124] Like these two states, TennCare aligns the episode definitions across MCOs.[125]

In addition, having a uniform risk-adjustment methodology could facilitate the refinement of the formula as more is learned from research and experience about what factors should be included. For instance, the NQF has suggested that risk adjustment might benefit from socio-demographic factors such as a patient's distance from hospitals and primary care physicians.[126] Meanwhile, one study has demonstrated that detailed risk adjustment at the episode level may exaggerate the impact of high-cost outliers.[127] A uniform risk-adjustment method across the three MCOs would provide clarity, which in turn should allow for greater discussion and implementation of whatever methodological changes may be needed.

Key Points & Recommendation

The following recommendation would solve the problem of unaligned risk-adjustment formulas among the three TennCare MCOs.

- ☑ **Consider requiring all MCOs to align risk-adjustment formulas.** TennCare should consider requiring all MCOs to use the same risk-adjustment methodology. This change will not be an abrupt departure from current requirements for providers since TennCare has already required MCO alignment on episode of care details, such as uniform gain and risk-sharing ratios, standard reporting metrics, and the definition of episode thresholds.[128]

Notably, standardization of the risk-adjustment formula does not fully remove variation in risk adjustment across payers if each payer uses only data specific to its insured population. Risk adjustment requires calculations with the average and distribution of a population, so the results will be different if the underlying populations are sufficiently different.[129] If all payers cover populations with similar health profiles and demographic characteristics, then this difference should be negligible. However, if one payer starts to cover a disproportionate share of the population from one region or with a certain health characteristic, then the potential impact on risk-adjustment levels across all payers should be examined.

Downside Risk

Introduction

TennCare's episodes of care include both upside and downside risk to providers. Downside risk impacts providers when actual costs of treatment exceed the costs of 10% of providers performing the same episode. In these circumstances, the physician or practice will be held responsible for a percentage of the difference. When providers have a small number of patients, one high-cost outlier could significantly increase costs and cause their risk-adjusted average spend to exceed the acceptable threshold. Many episodes of care programs include protections for physicians against these high-cost outliers.

Challenges

TennCare faces a specific problem with including low-volume providers in episodes of care. Low-volume providers are more vulnerable to the effects of downside risk and many, especially primary care providers, are hesitant to embrace two-sided risk.[130] Low-volume providers also may not have the capacity to effectively use the episode reports provided by payers.

We heard providers express concern about several factors related to downside risk. These concerns include factors that affect the amount and calculation of risk-sharing payments:

- Episode spending is subject to factors outside of the quarterback's control.
- High-cost outliers could cause quarterbacks to be eligible for losses due to risk-sharing.
- Providers will owe risk-sharing payments after the first year of episode implementation when they may not have a good sense of how much their TennCare patients cost.
- The percentage of risk-sharing payments that providers would owe is too high.

A second group of concerns focuses on the type of providers that could be subject to risk-sharing payments:

- Low-volume providers may have an insufficient number of episodes to calculate an appropriate average risk-adjusted spend.
- Low-volume providers may not effectively respond to TennCare's incentives.
- Providers may treat high-cost patients and be unable to meet the TennCare cost targets in the first year, even if they improve quality.

Additionally, providers designated as quarterbacks may fear that many clinical factors are outside their control, but could still affect the patient's spend. This fear could cause providers to avoid treating complex patients with higher utilization due to concerns that they would not be able to keep the patient's costs below the risk-sharing threshold.[131]

Best Practices

Outliers

TennCare has taken steps to address providers' concerns about spending on individual patients and total spending for episodes. TennCare currently excludes any outliers that are more than three standard deviations above the average risk-adjusted spend. Ohio uses the same standard for excluding outliers in their episodes.[132] Arkansas's episode of care initiative, which was the model for TennCare's reforms, also excludes outliers above three standard deviations.[133] This adjustment allows providers with especially high-cost patients to exclude these patients from their average spend that will be calculated for the risk and gainsharing.

Phase in Requirements

The NQF convened a multi-stakeholder Rural Health Committee to address the challenges facing rural and low-volume providers and determine ways to engage them in payment reforms that require quality measurement. NQF's overarching recommendation was to make participation mandatory, but to phase in the requirements to allow providers time to adjust measurement to low-volume cases.[134]

Phase in Downside Risk

The Medicare Comprehensive Care for Joint Replacement (CJR) model is a five-year Medicare demonstration that is testing episodes of care for hip and knee replacement. The model will feature a gradual phase-in of downside risk and a lower stop-loss limit in order to give hospitals more time to adapt to the CJR model.[135] Specifically, hospitals will not be responsible for risk sharing or repayment until the second year, and the amount of reward payments will increase over the five-year period. Since this model does not include hospitals outside of Metropolitan Statistical Areas (MSAs), it may be even more important to phase-in downside risk for low-volume rural providers.

Key Points & Recommendations

The following recommendations reflect potential solutions to providers' fears of downside risk. They provide a range of options, from excluding low-volume providers entirely to transitioning more slowly to a full two-sided risk model. These recommendations are not necessarily stand-alone and could be used in combination with each other.

- ☑ **Consider allowing providers who exceed the average risk-adjusted episode cost, but meet the defined quality measures, to pay lower penalties (e.g. less than 50 percent).** Providers who meet cost targets but fail to achieve all quality measures do not receive reward payments.[136] This principle could also be applied to penalty payments: providers who do not meet cost targets but do achieve all quality measures would not have to pay the full penalty. Providers who maintain quality of care but do not meet cost reduction targets should be treated more positively than providers who neither maintain quality nor reduce cost.

  This recommendation reaffirms that the goal of episodes of care is to maintain quality *and* reduce cost, not solely reduce cost. This is an additional way for low-volume

providers to shield themselves from the full effects of downside risk. It gives relief from risk sharing to those providers who worry that they will be unable to meet cost targets when they treat high-cost patients, even though they are meeting the quality targets.

☑ **Consider excluding providers who do not treat a minimum number of valid episodes in a given year from two-sided risk.** Ohio and Arkansas both exclude providers who do not meet a minimum case volume of five valid cases per 12-month period; Ohio does not even send episode performance reports to providers who have fewer than five valid cases.[137] This is a simple step to remove the lowest-volume providers from the two-sided risk model. It would eliminate the potential losses from downside risk faced by the lowest-volume providers.

While it would eliminate downside risk for the lowest-volume providers, this recommendation would not bring these providers into the custom of using two-sided risk for episodes of care. This goes against the primary recommendation of the NQF Rural Health Committee, and leaves practices unprepared if they ever have more than five valid episodes.

An important consideration for this recommendation is what proportion of total practices have fewer than five valid cases. If many practices do, then their exclusion could distort the two-sided risk model; if few practices do, then it would have a smaller effect on the two-sided risk model.

☑ **Consider giving low-volume providers solely limited upside risk rather than larger upside and downside risk.** This recommendation incentivizes low-volume providers to reduce cost, and protects them from the downside risk of high outliers. It follows the NQF Rural Health Committee recommendation of making rural and low-volume providers engage in payment reform, but does not force them into immediately facing downside risk.

This recommendation could be phased out over a period of two years so that low-volume providers eventually face two-sided risk. This is best used as an intermediate step to further ease the introduction of downside risk to low-volume providers. It addresses concerns that low-volume providers are not ready to immediately face downside risk, while also preparing them for it and setting a clear timeline for when it will be introduced. Like the Medicare CJR model, TennCare could start with a lower upside risk and then increase the potential reward payments as the downside risk is phased in.

Data Reports

Introduction

An important component of TennCare's episodes of care initiative is the provision of a quarterly data report by each TennCare MCO to the quarterback, the provider who has the best opportunity to influence the quality and cost of an episode. These reports show the quarterback how he or she performed on episode cost and quality by including key information, such as the number of episodes, average risk-adjusted episode cost, and quality metric results. These reports are designed to help providers understand the cost and quality of care given to patients during each episode in which they are designated the quarterback, and identify where there is potential for practice changes, care coordination, and documenting best practices.[138]

TennCare considers these episode of care reports a key tool for promoting the use of clinical pathways and evidence-based guidelines, encouraging coordination among providers, reducing ineffective and/or inappropriate care, and rewarding high-quality care.[139] However, interviews with multiple stakeholders in Tennessee indicate that these reports do not contain sufficient information to guide providers in making appropriate practice changes. Furthermore, stakeholder interviews point out that many participating quarterbacks are not yet viewing the reports. In addition, interviews suggest the current format of provider reports can be improved upon. This section addresses how episode of care reports can be optimally designed and communicated to best enable quarterbacks to provide high-quality and efficient care for acute medical and behavioral treatments and conditions.

Challenges

The episode of care reports are intended to "provide PAPs (quarterbacks) with significant data and information related to episodes of care for which they are accountable, to enable greater understanding of the drivers of performance. With actionable information, PAPs should have transparency into underlying costs and quality indicators for their episodes."[140] However, multiple stakeholder interviews indicated that the reports can be improved upon.

Currently, the provider episodes reports include detailed quality and cost information that was previously unavailable to providers. For example, the reports start with a summary page outlining the number of episodes, the average risk-adjusted cost, eligibility for gain- or risk-sharing and the relevant amount, and quality metrics.[141] The reports then provide additional detail on that provider's cost and quality for the valid episodes and provides a comparison to the average cost and quality among all providers. PAPs also receive information on cost breakdowns by care category for an episode (e.g., inpatient, outpatient, pharmacy). The information included in the report gives providers an opportunity to target high-cost care areas and improve quality for their patients.

Meetings with the Tennessee Medical Association, Tennessee Hospital Association, and BlueCross BlueShield of Tennessee (BCBST) included discussion about provider feedback that indicated providers would like to see more data and more transparency in the reports including claims-level detail, pharmacy detail, and quality metric detail.[142] For example, the reports' cost

breakdown by care category only shows the overall costs and number of claims for each category (e.g., inpatient professional, pharmacy, emergency department, outpatient lab), but does not include more detailed price or utilization data for providers to understand the specific cost drivers within each category. MCOs understandably wish to keep price details proprietary to protect their provider contracts, so any improvements to the existing provider report will have to be weighed against the feasibility of such changes.

The most important factor determining the usefulness of these reports is whether quarterbacks actually review them. One MCO indicated that only a small percentage of quarterbacks have opened the quarterly reports since they were first sent in May 2014. For 2015 reports (released in the 2nd, 3rd, and 4th quarter), "only 53 of 194 group contract IDs with valid episodes for wave 1 and wave 2 episode types have downloaded the reports (a rate of 27.3%). For contract IDs representing individual providers, the percentage rate is much lower at 10.9% (107 out of 983). The combined results showed that only 13.6% of quarterbacks have downloaded reports in 2015."[143] These estimates suggest that the vast majority of quarterbacks are not opening their quarterly reports, which is just the first step before they could be used to guide practice changes. It is likely that as payments and penalties are implemented after the first performance period, quarterbacks may become more interested in viewing their reports. However, the MCO believed it was too early to witness any trends in which quarterbacks (e.g., high vs. low volume, high vs. low spenders) are using their reports.

The utility of episode of care reports is especially uncertain for low-volume providers who likely have too few patients in each MCO's quarterly report to see any patterns revealing where quality is consistently low or spending is consistently high. Even if sufficient data is available to guide practice change, low-volume providers face unique challenges in using the data. In small practices that are not part of a larger system, providers may lack the time or support staff to review quarterly reports and make necessary changes to improve quality and reduce costs, such as coordinate with other providers involved in an episode. Cumberland Center for Healthcare Innovation (CCHI) shared that rural providers like their members are so busy trying to see enough patients in a timely manner to "keep their doors open," while still providing quality care, that they do not feel they have time to engage in any additional reform efforts beyond what they are currently engaged in.[144] Unless payments and penalties for a small number of episodes offer a strong incentive to review reports and alter behavior, it may be especially unlikely that low-volume providers will use episode reports.

Best Practices

Stakeholder meetings revealed that many providers desire more detailed, transparent, and actionable data in the episode of care reports in order for them to further understand and influence the specific quality and cost drivers for the episodes they coordinate. Research supports this assertion: a 2015 RAND Corporation analysis found that when data on prices were unavailable to providers, they had a limited ability to contain the costs of care.[145] In contrast, when providers were able to break procedures down to their parts, see the costs of each component, and compare their performance to other providers, they were able to make decisions that improved quality and reduced costs.[146] The final evaluation of the Medicare Acute Care Episode (ACE) demonstration found similar results. As part of the ACE demonstration,

physicians were given monthly report cards with specific cost and quality information, such as variation in the prices of comparable medical devices. These report cards served as a driver for discussions among physicians and between physicians and administrators to identify ways in which costs could be reduced and procedures made more efficient.[147] In these studies, quarterbacks used the detailed data to reduce costs in two main ways: by standardizing care procedures and medical products across collaborating providers,[148] and negotiating with suppliers for lower prices on these products.[149]

However, providing more information in the quarterly reports is not likely to be sufficient to engage providers in TennCare's episodes of care initiative. Research is beginning to examine how health care reform and other value-based initiative can add significant complexity and workload to an already time-challenged and overburdened health care workforce. The cumulative chronic stress imposed by multiple regulatory, insurance, federal, and state forces that do not coordinate well with one another has the potential to affect health care workers on personal, physical, emotional and cognitive levels, which in turn may adversely affect quality of patient care.[150] Given these concerns, it is not surprising that a systematic review of innovations in health care organizations recommends that to increase uptake of reform initiative. the changes should not add complexity or time to workflow.[151] Providers may be much more likely to utilize episode reports if they can be comprehended easily and quickly to inform practice decisions.

Key Points & Recommendations

The quarterly data reports were a focal point of several conversations with stakeholders regarding TennCare's episodes of care initiative. The recommendations here address how episode of care reports can be optimally designed and communicated to best enable quarterbacks, particularly low-volume providers, to provide high-quality and efficient care for acute medical and behavioral treatments and conditions.

- ☑ **Consider opportunities for improvement to existing episode of care reports, including encouraging payers to provide more detailed, transparent, and actionable information where feasible.** TennCare should consider requiring claims-level cost information in the quarterly reports, or at least a more detailed summary of cost variation. Without access to more detailed price and utilization data, quarterbacks may find it difficult to know the specific quality and cost drivers for the episodes they coordinate. This may be especially problematic for low-volume providers who have too few patients in each MCO's quarterly report to see any patterns revealing where quality is consistently low or spending is consistently high. Including claims-level detail, for example, can better inform practice change and promote more buy-in from providers requesting this additional information.

  Recognizing the challenge of maintaining the proprietary nature of provider contracts, it would likely be important to summarize additional cost data. One option could be to share specific claims data in instances where it is above an acceptable level (e.g. in the top 20 percent of costs for a given procedure). Another option would be to limit this claims-level data to only certain procedures that are known to be high cost in a given

episode. Finally, a third option could be to provide summarized claims data by procedure rather than just category, but not by provider.

- ☑ **Explore ways to more succinctly deliver key information to quarterbacks, such as through an executive summary of each quarterly report.** Many quarterbacks, especially low-volume providers with less support staff, may be too time-challenged or overburdened to thoroughly review data reports, draw accurate conclusions about quality and cost drivers, or investigate ways to improve care and cut costs. Given that the vast majority of quarterbacks are not even downloading their reports, payers should consider alternative ways to deliver this information. For example, quarterbacks may be more likely to read a brief executive summary accompanying each quarterly report. This summary may draw on more detailed claims-level and quality data and provide actionable information about specific providers, procedures, supplies, locations, etc. that drive high costs or low quality for a given episode. This summary may also include more generalized suggestions of best practices, for example, based on an MCO's analysis of the highest-performing quarterbacks who achieve quality metrics at the lowest average cost. These summaries could accompany all quarterly reports or be selectively targeted to low-volume providers, high spenders, or other groups at risk of underperforming. A brief summary could appeal to time-constrained providers and deliver concrete and consistent guidance for cost-effective care.

- ☑ **Assess the barriers inhibiting quarterbacks from reviewing episode of care reports.** For any version of an episode report to be useful, a quarterback who has the best opportunity to influence the quality and cost of an episode must first view it. TennCare and its payers should consider investigating why the vast majority of quarterly reports are not being downloaded. A focus group or phone survey of non-complying quarterbacks may provide useful feedback to inform the design and delivery of episode reports in order to be optimally utilized by providers to promote high-quality and efficient care.

Part III: Physician Education & Outreach

Physician Education and Outreach

Introduction

Health care providers are on the front lines of implementing Tennessee's innovative payment and delivery system reforms around PCMHs and episodes of care. In order for these strategies to be fully and effectively realized, physicians must possess both awareness and a clear understanding of each of the transformations. However, educating physicians across rural and urban areas —especially low-volume providers—about complicated new requirements is a complex undertaking, and such an effort stands a lower chance of success if physicians perceive that these efforts are burdensome.

Given the significant challenge of educating physicians about these reforms, and the recognition that physician engagement is critical to drive effective implementation, we recommend that TennCare develop and launch a robust provider outreach strategy that addresses stakeholders' concerns, incorporates best practices, and reflects physician culture.

Challenges

Tennessee's outreach challenge is multifaceted. First, the sheer scope of communicating with a large number of providers across widespread geographic and culturally distinctive areas creates a practical hurdle to implementation. Second, engagement with both the PCMH model and the episodes of care transformation will require physicians to change their behaviors significantly, and therefore will necessitate robust support, education, and resources. Third, implementation will only succeed if physicians buy into the effort. Therefore, an effective communications strategy should engage physicians as partners and incorporate elements of physician culture to alleviate the risk of being perceived by providers as a bureaucratic barrier to providing quality care.

As of October 2015, there were more than 8,300 PCPs and 9,600 specialty practices in the state, supported by thousands of additional nurses and care managers.[152] Tennessee's ambitious effort to include 65 percent of TennCare members in PCMHs by 2020, to designate at least 200 Community Mental Health Centers as Health Homes, and to enact 75 episodes of care by 2020 will require outreach and training for thousands of busy physicians and healthcare professionals preparing them for significant and complicated changes in care delivery and payment. Moreover, these providers operate in varied practice settings, serving diverse sociocultural needs across a wide geographic area. Providers themselves reflect the unique composition of these distinctive communities and cultures. Finally, as our analyses indicate, across both urban and rural counties, nearly 87 percent of TennCare practices are responsible for fewer than 500 TennCare patients each. This dispersed distribution heightens the complexity of education and outreach efforts, as these low-volume providers lack economies of scale and may work concurrently with several disparate payers.

Fortunately, the SIM grant supporting TennCare's reforms included built-in mechanisms and funding for outreach and provider training, and stakeholder meetings have already been undertaken. Yet, many stakeholders in the state still expressed strong interest in additional

communications between TennCare and its providers overall. TennCare staff reported that engaging providers is one of the primary challenges to ensuring that reforms are implemented successfully, especially given that many providers are focused on delivering care and are less engaged in health care policy or reform efforts.[153] As mentioned in the previous section, one of the TennCare MCOs expressed concern that many providers did not open their reports related to episode performance, suggesting that current communications are not reaching physicians, partially due to providers' limited time.[154] Furthermore, without clear communications and an effective feedback mechanism to report challenges or barriers to implementation, some physicians were left with fears and uncertainty regarding the reform efforts.

Both research and conversations with Tennessee stakeholders indicate the need for intensive technical assistance and educational outreach to providers in order to implement the reforms. A study of 225 rural health clinics found that most need "substantial support and technical assistance to build the capacity and systems to meet the standards for NCQA Recognition as a PCMH."[155] Similarly, robust education and support is necessary for implementation of episode-based payment reforms. For example, one study of a California episode-based payment pilot found that provider "uncertainty about state regulatory decision making" contributed to program-wide implementation failure.[156]

Another body of research suggests that substantial training in using EHRs is an important component of the education and support necessary for many providers, given that a usable EHR system is a critical prerequisite for effective implementation of both PCMH and episode of care transformations. Research suggests that while providers are enthusiastic about the "promise of EHRs," EHR systems are often overly complex and difficult to use.[157] A 2013 RAND report found that inadequate EHR technology "significantly worsened professional satisfaction" for physicians, largely due to "poor EHR usability, time-consuming data entry, interference with face-to-face patient care, inefficient and less fulfilling work content, inability to exchange health information between EHR products, and degradation of clinical documentation."[158] In addition, the report found that many practices are unable to adopt EHRs because they are prohibitively expensive.[159]

Finally, successful outreach is challenging because it must take into account physician culture, and therefore must address widespread provider concerns regarding physician autonomy amidst contemporary health reform efforts. With changes in regulation and reimbursement, the number of physicians employed by hospitals has increased and the number who are self-employed has decreased. According to data reported by the American Medical Association, 39 percent of physicians practiced independently in 2012 compared to 57 percent in 2000.[160] In this context, according to a 2013 Jackson Healthcare study, physicians reported decreasing autonomy as the number-one reason for job dissatisfaction, followed by "low reimbursement" and "administrative hassles."[161] As the chairman of one health system commented, "Physicians are working harder and longer hours for less reimbursement. Moreover, they feel like insurers, government and hospitals dictate how they can treat patients. If we continue to devalue the experience and skills of our physicians, they will become the most expensive data entry clerks in the nation."[162] Research suggests that physicians value autonomy as a tool to deliver quality treatment to their patients. The aforementioned 2013 RAND report found that physicians report satisfaction when their practices enable them to provide high-quality care to their patients without internal

obstacles, such as leadership that is not receptive to quality improvement ideas, or external obstacles, such as duplicative data entry requirements, prior authorizations, or payer refusal to cover necessary medical services.[163]

Leaders of United Neighborhood Health Services, a PCMH that operates 12 clinics in Tennessee, echoed the concern that imposing a major cultural shift within an ingrained medical culture is difficult, but also indicated that such an effort is more successful when providers communicate with other providers.[164] They believed that doctors are less receptive to policy changes delivered by administrators, but that clinicians are more open to engaging in communications and outreach efforts delivered by fellow physicians.

As of November 2015, TennCare had facilitated approximately 500 meetings with 250 stakeholder groups in order to prepare stakeholders across the state for impending transformations.[165] TennCare has held 11 meetings since July 2015 with its PCMH and Health Home Technical Advisory Group (TAG) members. The PCMH TAG includes 20 providers from across the state; the Health Homes TAG includes 18 providers. In addition, TennCare is planning to collaborate with 5-7 providers per episode to develop the 75 planned episodes.[166] The TAGs for the first three episodes of care have been completed, while the TAGs for the next episodes to be rolled out are now underway.

Despite these efforts, broad dissemination of information and engagement with providers has remained a challenge. Research underscoring physicians' concern for quality, coupled with TMA's perception that information has not been effectively disseminated suggests that, while education is a challenge, a more successful physician engagement strategy would enable the state to partner with physicians in their shared quest for quality.

Best Practices

Outreach Networks

The literature on information dissemination highlights the importance of utilizing tiered network systems to communicate with culturally and geographically diverse stakeholders and to foster collaboration.[167] Several networks have already been established to educate physicians about systems changes surrounding episode-based payments. For example, the Centers for Medicare and Medicaid Services (CMS) introduced the Medicare Learning Network Connect (MLN) and the CMS Quality Improvement Network-Quality Improvement Organization (QIN-QIO) to disseminate information about episode-based payment transformation changes while also helping practices improve quality of care.[168] Similarly, the U.S. Department of Health and Human Services' Health Resources and Services Administration (HRSA) has funded Area Health Education Centers (AHEC) to build partnerships between academic centers and community-based physicians to support providers in underserved areas with continuing education.[169] Each of these organizations operates through multi-tiered nodes to publicize video education modules, collaborative resources on best practices, tools for data analysis and practice improvement, and technical assistance and support.[170] These collective strategies have aided primary care practices in adapting to regulatory change.[171] Drawing on existing Medicare information dissemination networks to educate providers on TennCare transformations would provide evidence-based

methods of education, alleviate the costs of re-creating communication infrastructure, and streamline provider interactions with a limited number of educators.

Supportive Resources for Transforming Practices

Strategies use multiple modalities, including collaboratives, to educate physicians

Research shows that providers who benefit from multiple forms of education and outreach—particularly on-site coaching and learning collaboratives—are able to implement reforms with greater success. These findings are consistent across states, settings, and reform efforts.

There is especially strong evidence for the benefit of in-person coaching and the support of learning collaboratives while implementing reform transformations. One study of provider educational support examined 30 small- and medium-sized practices participating in pilot PCMH transformation programs in Rhode Island, Colorado, and Ohio. It found that transformation coaches and participation in learning collaboratives were among the most effective tools in helping small practices adopt PCMH techniques.[172] Moreover, findings from the Rhode Island pilot suggest that, when provided with sufficient support, smaller practices can implement these significant changes relatively quickly. Practice leaders in the study commented that the in-person coaching was one of the most helpful tools, as coaches were able to combine tailored knowledge of each individual practice with understanding of best practices from across the country.[173] Practice leaders also emphasized that learning collaboratives were particularly effective in encouraging physicians to lead development of their own innovative solutions to implementation challenges, while also cultivating cooperation and strategy sharing among similar providers. Participants described the collaboratives as "a nice balance between letting the practices develop their own local solutions, but also jointly... By far the strongest part of the program was the interaction with the other physician offices that were participants, simply the sharing of ideas."[174] These sentiments were echoed by nine practices participating in the Maryland Learning Collaborative, where providers found the learning collaborative model "instrumental" in helping them adopt the PCMH model.[175]

While certain types of assistance, such as in-person training and learning collaboratives, have been particularly important educational tools, research also emphasizes the benefit of utilizing multiple complementary forms of educational support. A study of 36 urban and rural practices undergoing PCMH transformation across 25 states examined the efficacy of using multiple forms of education versus stand-alone internet resources in educating providers. According to study protocol, half of the practices followed a highly structured facilitated approach, which included "an intense combination of on-site assistance from practice change facilitators, learning sessions, national consultants, and preselected vendors of a range of health information technology," while the non-facilitated approach included access only to online resources.[176] Practices that received the facilitated intervention implemented significantly more PCMH components.[177] Numerous studies suggest that practices receiving multiple types of support are more likely to be successful at implementing the PCMH transformation. These findings hold with respect to episodes of care transformations as well. For example, a Mathematica Policy Research study of episode-based payment systems found that "innovative avenues for provider engagement, training, technical assistance, and shared peer-to-peer learning opportunities" were essential to facilitate practice changes and overcome barriers.[178]

Strategies maximize the usability of electronic health records (EHRs)

Many organizations—including several in Tennessee—are deploying best practices related to physician education and support to help providers overcome barriers to engaging effectively with EHR systems. For example, Cumberland Center for Healthcare Innovation (CCHI) provides its practices with integrative support software and training that facilitates information sharing across 14 different EHR systems.[179] In addition to resolving the challenges of compatibility and data sharing between EHR systems, the software allows providers to measure their compliance with CMS standards and to manage population health data, two elements that are crucial for successful implementation of reforms.[180] CCHI's clinical analytics software supports providers in overcoming challenges related to current EHR systems without requiring them to overhaul their existing information technology systems. Moreover, CCHI's Chief Information Officer ensures that providers receive necessary training in how to utilize this software.[181]

The Tennessee Regional Extension Center (tnREC), a technical assistance center established by the Office of the National Coordinator for Health Information Technology, has also used education to facilitate effective EHR use by assisting more than 1,300 providers with selection and implementation of EHRs.[182] Although its grant has expired, tnREC's success in educating and engaging providers demonstrates how technical support resources can enable providers to establish and utilize EHRs effectively.

Finally, research suggests that employing support staff to facilitate EHR use can encourage physician engagement.[183] For example, several practices have utilized a "flow manager" to ensure that physicians limit their engagement with EHR systems to tasks that require a physician's training. Others have used scribes and dictation services to decrease data-entry requirements and reduce EHR interference with face-to-face patient care.

By providing various resources, ranging from technical assistance and education to support software or transcription services, organizations across the country have created solutions to ease the current inefficiencies of the EHR system, allow for collaboration across providers, and educate providers on the optimal use of EHR systems.

Strategies employ user-friendly online communications

Well-designed state Medicaid websites provide a natural vehicle to communicate information to providers about health reform initiatives. Optimal websites are easily navigable and aggregate important information succinctly in clearly labeled sections in order to optimize user experience and present information effectively. A user-friendly website that allows busy providers seeking information about reform initiatives to find answers quickly can help relieve uncertainty and align providers with reform efforts.

The Ohio Medicaid website is one such example. It includes a designated "provider" section, accessible from the website homepage.[184] Upon entering the section, providers immediately view a phone number they can call for technical assistance. The provider webpage also incorporates several clearly subdivided sections rather than inundating providers with all of the materials on a single page. A clearly labeled "Payment Innovation" tab allows physicians to access a Frequently Asked Questions (FAQ) document, explore information by episode, view a sample episodes of care report, read information on the methodologies used for risk adjustment and threshold

setting, and access guides on how to understand episode reports. Through careful organization and presentation, the Ohio Medicaid website enables providers to locate practical information quickly and easily.

Well-designed websites may showcase multiple features, including informational videos, fact sheets, and other educational materials. For example, the Arkansas Center for Health Improvement created an orientation video featuring real providers and animated graphics to succinctly and clearly explain the state's changes to its health care payment and delivery systems.[185] By incorporating video in addition to other modalities, the Arkansas Center for Health Improvement website enables individual providers to interact with the interface and digest critical information in a personalized fashion.

Interventions Tailored to Physician Culture

Strategies allow for flexibility and encourage physician leadership

Research suggests that the most effective education strategies value and capitalize upon physicians who take on leadership roles and promote doctors' autonomy by allowing for flexibility in implementation.[186] These initiatives treat physicians as partners and foster bottom-up implementation of reforms rather than policies that may be perceived as rigid or imposed. Studies show that when physicians are viewed as partners rather than as consumers of quality initiatives and when practice change models are driven by evidence, physicians will be more likely to engage in change efforts.[187] For example, a learning collaborative in Portland, Oregon encouraged participating physicians to share best practices, set up a learning center, and hold learning sessions every six weeks.[188] An evaluation of participating practices showed that allowing for flexibility and encouraging physician-leaders to show initiative were essential for the success of primary care transformation and helped to cultivate the strong support of participating physicians that fueled the project's success. As the authors of the report described:

> Without the 'incubator' experience that organizational leaders shared, they would not have developed the passion for transformation or the conviction to model personal qualities that they were trying to instill within their organizations. These facilitative and modeling aspects of engaged leadership may not have been cultivated by a rigid rollout of a predetermined intervention.[189]

Strategies are evidence-based

The literature surrounding provider engagement highlights the increased likelihood of physician adoption of a given reform when the novel approach is substantiated by empirical evidence.[190] Physicians, particularly younger ones, are trained rigorously in the methods of "evidence-based medicine," a system through which they learn to evaluate innovative strategies in the context of the empirical literature. Consistent with this empirical emphasis, providers conceptualize credible practice transformations as those that are corroborated by data. At McLeod Regional Medical Center in South Carolina, management and physicians worked together using evidence-based practices to achieve scores of 99 percent on all CMS Core Measures of care, improved medication safety, and decreased mortality rates due to myocardial infarction. In the words of their Vice President of Medical Services:

> If we have a secret, it is that we have become a 'learning organization' and that appeals to life-long learners, which physicians are. We like to say that our improvement work is 'Physician-Led, Evidence-Based, Data-Driven,' but what we're really saying is that we believe that physicians have a deep-seated need to learn together, with evidence and data at the foundation of the learning.[191]

Through this emphasis on evidence-based reforms, the administration of McLeod Hospital was able to engage physicians in the implementation of a shared quality agenda.

Strategies emphasize a shared agenda based on common values

Research also suggests that effective education and engagement occurs when providers perceive an alignment of values between themselves and those implementing reforms.[192] A RAND study of nearly 700 physicians in six states indicated that physicians are motivated by elements of practice change that improve their ability to deliver quality care. The authors found that "when physicians perceived themselves as providing high-quality care or their practices as facilitating their delivery of such care, they reported better professional satisfaction. Conversely, physicians described obstacles to providing high-quality care as major sources of professional dissatisfaction."[193]

Similarly, a study of 16 practices in Michigan focused on implementation of the PCMH model found that delivery reforms were adopted more effectively in practices where providers viewed the reforms as inherently valuable. The authors of the study report that the most successful practices "viewed the PCMH as intrinsically valuable for their patient care and quality goals [and] regarded the financial incentives for PCMH functions primarily as offsetting costs to enable them to provide desired functions."[194] In contrast, the model was implemented less successfully in practices that "viewed the PCMH as an externally imposed program, regarded the financial incentives as generally an insufficient reward for meeting externally imposed requirements, felt a need for external teaching about the PCMH and for external direction in promoting change."[195] As both cases illustrate, effective provider education incorporates an emphasis on alignment of values with a shared commitment to improving patient care.

Strategies incorporate physician-friendly language

Research emphasizes the importance of using physician-relevant terms in communications with providers.[196] For example, rather than stressing "reduced supply costs," physician outreach should underscore benefits in terms of "better patient outcomes" and "less wasted time for physicians."[197] Furthermore, in addition to using physician-relevant terminology, direct communications should be aware of the connotations of what may be perceived as politically charged language. As the Institute for Healthcare Improvement emphasizes: "It is important to choose words carefully in communications about the project. Terms such as 'accountability' and 'performance reports' can be loaded with unintended meaning, and so it is important to regularly audit your communications to make sure that your language is engaging and not inflammatory."[198]

Key Points & Recommendations

TennCare plans to provide training and support to providers undergoing PCMH transformation beginning in 2016 for two years.[199] Broad guiding concepts for this effort have been outlined by the PCMH Technical Advisory Group, including the need for a curriculum that can be tailored to practice needs and characteristics (such as size or rural location). The following recommendations will assist TennCare in educating providers through development of a more detailed and robust communications strategy that reflects both the evidence-based principles discussed above and the expressed concerns of stakeholders.

- ☑ **Consider incentivizing physicians to attend PCMH and episodes trainings by offering Continuing Medical Education (CME) credits to participants and by making trainings free.** TennCare should work to secure approval from the Accreditation Council for Graduate Medical Education (ACGME) in order to offer CME credits for providers who complete training sessions. These credits are required on an annual basis for physicians to maintain their board licenses. Offering free CME-accredited trainings will incentivize doctors to attend and will help these trainings have a greater statewide impact. This recommendation would not impose additional burdens on doctors' time, given their professional requirement to attend CME trainings.

- ☑ **Consider ways to create a provider support and outreach coalition through existing networks.** TennCare should work with provider associations through previously established educational networks, including Tennessee AHEC and Atom Alliance, the state's QIN-QIO, to establish an integrated provider education and outreach initiative. AHEC and similar organizations possess the capacity to organize CME-granting collaborative learning opportunities such as conferences, tele-conferences, and video modules, while Atom Alliance is skilled in providing technical assistance to providers. Educating physicians through collaborations with existing networks would reduce the costs of re-creating outreach infrastructure and streamline provider interactions with organizations that are experienced in physician education. Designing networks with tailored support for both urban and rural practices would enhance the ability of these networks to address the unique needs of low-volume providers in different settings.

- ☑ **Develop an enhanced online toolkit for providers and publicize it throughout the state.** TennCare should optimize the Tennessee Health Care Innovation Initiative website for Tennessee providers seeking to understand and adapt to changes in the state's health care payment and delivery system. Specifically, the next phase of the website should be designed with an emphasis on provider experience. For example, the "provider" landing page should prominently include a clearly labeled phone number that providers can call for assistance, along with a well-organized aggregate of the practical information necessary for providers to engage with the episodes of care and PCMH reforms. Simple organization, with critical information labeled clearly, could allow for easier navigation. Nestled under an "episodes of care" section of the provider webpage, the website could incorporate two sections: an "episodes of care, by episode" section and an "episodes of care, by quarterback" section. Under the "episodes of care, by quarterback" section, providers would be able to select their specialty and view information on all episodes for

which they would be responsible quarterbacks. In the "episodes of care, by episode" section, providers could view a list of all episodes and could select each one for further information. Within each episode, a fact sheet would give providers guidance on how to improve quality of care, reduce spending, and qualify for gainsharing for that specific episode.

In order to serve as an optimal educational tool, the website could also incorporate several modalities. An introductory video, along with brief videos embedded on the homepage of each major reform strategy, featured prominently on the website could orient providers to reform initiatives and address their most common concerns.

Finally, in order to draw visitors to the website, TennCare should work with existing physician outreach networks to publicize the site and to incorporate links to the TennCare provider portal onto external organizations' homepages.

☑ **Offer multiple forms of education and training to assist practices implementing PCMH and episodes of care.** Based on the research described above, TennCare's education and training assistance should include mandatory on-site coaching, along with in-person trainings, webinars, and online resources. Given that our data analysis revealed the importance of reaching both urban and rural low-volume providers, online resources could provide flexibility and be especially important to support the many low-volume providers in rural areas who may be less able to attend in-person trainings. At minimum, practices should receive on-site coaching in addition to at least two other forms of support. The state should also explore, in partnership with the existing educational networks described above, establishing a learning collaborative for practices transitioning to PCMH.

☑ **Cultivate models of outreach, such as learning collaboratives, that rely on partnerships with providers in order to facilitate physician leadership and engagement.** Physician-leaders should play a central role in outreach efforts. TennCare should partner with physicians and practices that have successfully implemented PCMH and episodes, as well as other similar reforms, to conduct joint trainings where they can share best practices and engage with colleagues to offer technical assistance. Senior physicians who lead such training sessions should be compensated. Learning collaboratives could be especially useful in environments where practices have close proximity; given the large number of low-volume practices in urban counties, this model could be a good fit for these areas.

☑ **Foster continuous two-way communications with physicians and facilitate effective implementation through use of a feedback system.** In order to establish an ongoing TennCare-provider partnership focused on effective implementation of both the PCMH and episodes of care models, and in order to avoid confusion following the release of the first set of episodes reports, TennCare should generate a mechanism to field constructive feedback from its providers. In addition, the system should incorporate a TennCare responsiveness plan to ensure that early glitches can be resolved effectively and efficiently.

- ☑ **Facilitate alignment of values between TennCare and its providers.** Throughout all communications and outreach targeting providers, TennCare should emphasize a shared commitment to providing high-quality care. In addition, strategies should be framed in terms of the empirical literature with careful use of physician-friendly language.

Conclusion

Tennessee, long a leader in health care, has engaged in an ambitious payment and delivery reform effort in TennCare. The Tennessee Healthcare Innovation Initiative, which includes both Primary Care Transformation and episodes of care strategies, shows a great deal of promise.

However, this report suggests that several challenges remain related to the engagement of low-volume TennCare providers. These providers are prevalent in both urban and rural settings, and cost data indicates that the challenge of high-cost patients will need to be addressed in both geographic settings and in both high and low-volume practices.

For the PCMH strategy, the challenges identified in this report relate to payment structure, eligibility and reporting requirements, health IT and practice resource pooling, and behavioral health integration. For the episodes of care strategy, the identified challenges relate to the alignment of risk-adjustment methodologies, provider downside risk, and the data reports provided to physicians and other providers. A crosscutting set of challenges relating to physician education and outreach also suggest an area of both promise and peril.

The recommendations for addressing each challenge provided in the report rely on the extensive literature of best practices that has developed as other states and health systems have worked to implement similar strategies. These recommendations were developed with the focus on further attracting or engaging low-volume providers in TennCare's reform efforts.

TennCare is working to ensure that patients have access to high quality, more coordinated care. We hope this report is helpful in enabling the state's innovation strategies to succeed at both reducing costs and improving care for patients in every practice setting.

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